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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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ROBIN CARNAHAN

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James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

DIRECTOR

BARBARA WOOD

•

EDITORS

BARBARA MCDOUGAL JAMES MCCLURE

•

ASSOCIATE EDITORS

CURTIS W. TREAT SALLY L. REID

PUBLISHING STAFF

WILBUR HIGHBARGER HEATHER M. KAMPETER

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2002.

EXECUTIVE ORDER
05-08

WHEREAS, the Division of Design and Construction within the Office of Administration was created by Section 8.120, RSMo, to supervise the design, construction, renovations and repair of state facilities; and

WHEREAS, the Division of Facilities Management within the Office of Administration was established by Executive Order 94-07 and Section 8.110, RSMo, to have responsibility for state leasing and facilities management; and

WHEREAS, prior to 1994, responsibility for state leasing and facilities management resided with the Division of Design and Construction within the Office of Administration; and

WHEREAS, the consolidation of the Division of Facilities Management and the Division of Design and Construction will benefit the citizens of the State of Missouri by promoting efficiency, avoiding duplication of services, and reducing costs; and

WHEREAS, the Governor, in consultation with the Commissioner of Administration, has determined that the best way to accomplish this consolidation is to abolish Division of Design and Construction and transfer its responsibilities and functions to the Division of Facilities Management.

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, including Article IV, Section 12, Missouri Constitution, Chapter 26, RSMo, and the Omnibus State Reorganization Act of 1974, hereby:

1. Abolish the Division of Design and Construction and transfer to the Division of Facilities Management the authority, powers, duties, functions, records, personnel, property, contracts, budgets, matters pending, and other pertinent vestiges of the Division of Design and Construction; and

2. Rename the Division of Facilities Management as the Division of Facilities Management, Design and Construction.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 2nd day of February, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
05-09

WHEREAS, the Missouri Head Injury Advisory Council was established in 1985 by Executive Order 85-06; and

WHEREAS, in 1986 the General Assembly gave the Missouri Head Injury Advisory Council statutory authority (Section 192.745, RSMo); and

WHEREAS, Section 192.745.2, RSMo assigned the Missouri Head Injury Advisory Council to the Division of General Services within the Office of Administration; and

WHEREAS, the Missouri Head Injury Advisory Council's responsibilities include promoting discussion of reducing the debilitating effects of head injuries and disseminates information on the prevention and rehabilitation of persons affected by head injuries, studies current prevention, treatment and rehabilitation technologies and recommends appropriate preparation and distribution of resources to provide services to head injured persons through private and public residential facilities, day programs and other specialized services, and recommending methods to improve the state's service delivery system and developing standards for funding or licensing of facilities, day programs and other specialized services; and

WHEREAS, the Department of Health and Senior Services' mission is to protect and promote the quality of life and health for all Missourians by developing and implementing programs and systems that provide information and education, effective regulation and oversight, quality services, and surveillance of diseases and conditions; and

WHEREAS, the Office of Administration and the Department of Health and Senior Services, with the consent of the Governor, have determined that the Missouri Head Injury Advisory Council should be assigned to Department of Health and Senior Services.

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, including Article IV, Section 12, Missouri Constitution, Chapter 26, RSMo, and the Omnibus State Reorganization Act of 1974, hereby transfer the Missouri Head Injury Advisory Council to the Department of Health and Senior Services by a Type I transfer.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 2nd day of February, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
05-10

WHEREAS, the Department of Elementary and Secondary Education is authorized pursuant to Article IX of the Missouri Constitution and created pursuant to Chapter 161.020, RSMo; and

WHEREAS, the Department of Social Services is created pursuant to Article IV, Section 37 of the Missouri Constitution and Chapter 660.010, RSMo; and

WHEREAS, the Department of Health and Senior Services is created pursuant to Chapter 192.005, RSMo; and

WHEREAS, the Department of Elementary and Secondary Education currently provides personal attendant care to individuals with severe physical disabilities to enable them to live more independently through the Personal Assistance Services Program; and

WHEREAS, the Department of Social Services currently provides access to health care for low-income elderly and disabled individuals through the Medicaid Program; and

WHEREAS, the Department of Health and Senior Services provides support services to help seniors and adults with disabilities maintain their independence and safety; and

WHEREAS, the transfer of in-home care programs and services to one state department would better serve the state's elderly and disabled clients; and

WHEREAS, consolidation of these services would increase efficiencies and eliminate duplication of efforts; and

WHEREAS, I am committed to integrating executive branch operations to improve the way the state delivers services.

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, including Article IV, Section 12, Missouri Constitution, Chapter 26, RSMo, and the Omnibus State Reorganization Act of 1974, hereby order the Missouri Department of Elementary and Secondary Education, the Missouri Department of Social Services, and the Missouri Department of Health and Senior Services to cooperate to:

1. Develop mechanisms and processes necessary to effectively transfer in-home services programs that serve the elderly and disabled individuals to the Department of Health and Senior Services;

2. Transfer all authority, powers, duties, functions, records, personnel, property, contracts, budgets, matters pending, and other pertinent vestiges of the in-home services programs to the Department of Health and Senior Services, by Type I transfer, as defined under the Reorganization Act of 1974; and

3. Take the steps necessary to maintain compliance with federal requirements, so as not to jeopardize federal financial participation with this consolidation.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 3rd day of February, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
05-11

WHEREAS, on October 5th 2004, the Centers for Disease Control and Prevention (CDC) received notification of an impending shortage of influenza vaccine which would result in limited availability of the vaccine during the 2004-05 influenza season; and

WHEREAS, the CDC, acting upon the advice of its Advisory Committee for Immunization Practices (ACIP), recommended that health care providers limit distribution of the available influenza vaccine to persons identified as falling within certain designated "high risk categories"; and

WHEREAS, Executive Order 04-22 was issued on October 25th 2004, directing all Missouri health care providers and others that possess influenza vaccine to limit their influenza vaccinations to persons in the high risk categories identified by the CDC; and

WHEREAS, the ACIP has expanded its original list of priority group designations to include other individuals because there is sufficient influenza vaccine to accommodate an expanded group and the ACIP desires to avoid the possibility of doses of influenza vaccine going unused; and

WHEREAS, the Missouri Department of Health and Senior Services (DHSS), upon the advice of its Division of Environmental Health and Communicable Disease Prevention (EHCDP), has determined that sufficient influenza vaccine doses are available for Missouri to meet the existing demand for influenza vaccine and has received requests from local public health agencies to expand the high priority groups to ensure that Missouri's available doses of influenza vaccine are used during the 2004-05 influenza season; and

WHEREAS, on January 18th 2005, DHSS requested that Executive Order 04-22 be rescinded to allow for the distribution of influenza vaccine according to the CDC/ACIP expanded priority group designations.

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby rescind Executive Order 04-22 and order that DHSS and all Missouri health care providers and others that possess influenza vaccine adopt the CDC/ACIP expanded priority group designations as soon as possible and update the designations as necessary.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 3rd day of February, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 6—Wildlife Code: Sport Fishing: Seasons, Methods, Limits

PROPOSED AMENDMENT

3 CSR 10-6.410 Fishing Methods. The commission proposes to amend section (1).

PURPOSE: This amendment provides an exception in the description of fishing methods for the Experimental Catfish Hand Fishing Season.

(1) Fish may be taken by the use of pole and line, trotline, throwline, limb line, bank line, jug line, gig, longbow, crossbow, underwater spearfishing, snagging, snaring, grabbing and falconry, but only as specifically authorized in 3 CSR 10-6.415 through 3 CSR 10-6.620. No person may attempt to take fish by rock or hand fishing, with or without hook **except as specifically authorized in 3 CSR 10-6.511**.

AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. Original rule filed June 13, 1994, effective Jan. 1, 1995. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Jan. 31, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with John W. Smith, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 25—Fiscal Management
Chapter 3—Miscellaneous Rules

PROPOSED AMENDMENT

9 CSR 25-3.030 Access for Inspection of Public Records and Fees for Copying of Public Records. The department proposes to amend sections (3) and (4).

PURPOSE: This amendment will bring the rule into compliance with legislative revisions to section 610.026, RSMo with respect to the department's charges for copies of public documents.

(3) *[Access]* **As provided under section 610.026, RSMo, access** to public records for a short duration of time during normal business hours will normally be provided without charge. The department may negotiate a space or rental fee with the requester to provide access to public records when the access will be for an extensive period of time or will otherwise be disruptive to the normal operations of the department. Copies of public records will be provided by the department for the following copy and search fees:

[(A) Photocopies $.25 per copy;
(B) Microfilm copies $.50 per copy;
(C) Clerical research time and $11.50 per hour;
(D) Professional research time $16.50 per hour.]

(A) Paper copies no larger than nine by fourteen inches (9" × 14")—$.10 per page;

(B) Duplicating time—an hourly fee not to exceed the average hourly rate of pay for the department's clerical staff; and

(C) Research time—the actual cost of research time.

(4) Fees for duplicating other types of records and other formats including electronic data shall be based on the actual cost of search and duplication or as otherwise provided by *[law]* **section 610.026, RSMo**.

AUTHORITY: sections 610.010—610.030 and 630.050, RSMo [1994] ***2000****. Original rule filed June 17, 1986, effective Dec. 1, 1986. Amended: Filed July 17, 1995, effective Feb. 25, 1996. Amended: Filed Feb. 1, 2005.*

PUBLIC COST: The state will experience a decrease of revenues of approximately eleven thousand dollars ($11,000) each fiscal year. See fiscal note.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment by writing to Mike Clark, Controller, Office of Administration, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Fiscal Note
Public Entity Cost

I. Rule Number and Name: **9 CSR25-3.030**

Type of Rulemaking: **DMH Fiscal Management – Miscellaneous Rules**

II. SUMMARY OF FISCAL IMPACT (Present a summary of fiscal impact. Use a separate row for each public agency or political subdivision affected.)

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
State of Missouri – General Revenue fund	Decrease in revenue of approximately $11,000 per fiscal year.

III. WORKSHEET (Present more detailed fiscal information.)

(see detail listed below in assumptions)

IV. ASSUMPTIONS AND METHODOLOGY. . (Present assumptions, references and methods of acquiring information that underlie the conclusions in the fiscal note. Examples of information that might be included here are the sources of information presented in the fiscal note, why those sources were chosen and eventualities that might cause the fiscal impact to be different from your estimate.)

The changes is section 610.026 would have a fiscal impact on the department, but to what degree is not certain. This part of the legislation would limit the copy fee to 10 cents per page. The legislation would not have an effect on DMH expenditures, however it would decrease revenues deposited into the General Revenue fund by DMH facilities. Department Operating Regulation 5.025, prescribes department requirements for charging fees for coping records and reports. Previously, the DOR stated that fees charged for copies are "the standard rates schedule established by the Office of Administration or the actual cost of document search and duplication". In the DMH Financial Policies and Procedures manual section 2-B-05, the rates are as follows:

A. Photocopies $ .25 per copy
B. Microfilm copies $ .50 per copy
C. Clerical search time $11.50 per hour
D. Professional search time $16.50 per hour

Revenue received department wide over the three fiscal years (FY2000-FY2002) for Fees for Copying Public Records (revenue source code 1862) has averaged $43,842. However, for FY03 and FY04 the average total revenues for this revenue source code decreased to $18,752. The reason for the decrease is that most DMH facilities were no longer collecting copy fees for copies provided to other state agencies.

Using this rate and assuming that all facilities were charging for the search time as well as the photo copy charges, the revenues received would decrease considerably. If the facilities have not been charging for the search time and were only charging the $.25 per copy, the new rate of $.10 per copy would decrease revenues by 60 %. Making the assumption that the same number of copies were made as in the past two fiscal years, revenues would decrease by approximately $11,000 (60%) to $7,500.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 3—Alcohol and Drug Abuse Programs

PROPOSED AMENDMENT

9 CSR 30-3.132 Opioid Treatment Program. The department proposes to amend subsections (2)(B) and (12)(A).

PURPOSE: The amendment will eliminate the word "urine" from the drug screen requirement. The amendment will allow oral drug screens that can currently be performed reliably. The amendment will revise the drugs analyzed for in order to conform to federal guidelines.

(2) Treatment Goals and Performance Outcomes. Opioid treatment services shall be organized to achieve key goals and performance outcomes.

(B) Performance outcomes related to these goals shall be measured in a consistent manner. Measures shall include, but are not limited to—

1. Increasing employment and productive activities. Clients should be involved in employment or other productive activities. For those persons who have been in opioid treatment for six (6) months or longer, seventy percent (70%) shall be working, attending job training or school, be a homemaker, or have a medically documented disability; and

2. Reducing or eliminating the use of illicit drugs. Random *[urine]* drug screening shall be used to measure the program's effectiveness in helping clients' progress toward this goal.

A. The following aggregate results shall be expected from random *[urine]* drug screening conducted each month—

(I) For all clients tested, seventy percent (70%) shall be free of all drugs; and

(II) For those clients tested who have been in opioid treatment for one (1) consecutive year or longer, eighty percent (80%) shall be free of opiates.

B. In calculating these performance outcomes, the following categories of clients may be exempted—

(I) Persons admitted to the program within the past ninety (90) days;

(II) Persons undergoing administrative withdrawal due to program infraction(s) or other circumstance; and

(III) Persons undergoing withdrawal against medical advice.

(12) Drug Testing. The program shall use drug testing as a performance measure and as a clinical tool for the purpose of diagnosis and treatment planning.

(A) Each sample shall be analyzed for opiates, methadone, *[amphetamines]* **marijuana**, cocaine, barbiturates, and benzodiazepines. Testing shall include other drugs as may be indicated by a client's use patterns. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each test or analysis must include any such drugs.

*AUTHORITY: sections 630.655 and 631.102, RSMo 2000. This rule originally filed as 9 CSR 30-3.610. Original rule filed May 13, 1983, effective Sept. 13, 1983. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Nov. 8, 2004, effective Nov. 18, 2004, expires May 16, 2005. Amended: Filed Nov. 8, 2004. Amended: Filed Feb. 1, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment by writing to Rosie Anderson-Harper, Mental Health Manager, Division of Alcohol and Drug Abuse, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 10—Office of the Director
Chapter 33—Hospital and Ambulatory Surgical Center Data Disclosure

PROPOSED RULE

19 CSR 10-33.050 Reporting of Healthcare-Associated Infection Rates by Hospitals and Ambulatory Surgical Centers

PURPOSE: This rule establishes procedures for reporting hospital and ambulatory surgical center healthcare-associated infection incidence data to the Department of Health and Senior Services.

(1) The following definitions shall be used in the interpretation of this rule:

(A) CDC means the federal Centers for Disease Control and Prevention;

(B) Central line means vascular infusion device that terminates at or close to the heart or in one of the great vessels;

(C) Central line-associated bloodstream (CLAB) infection as defined by the CDC means central line-related bloodstream infection as referred to in section 192.667.12(3), RSMo;

(D) Cesarean section means obstetrical delivery by Cesarean section;

(E) Department means the Missouri Department of Health and Senior Services;

(F) Healthcare provider means hospitals as defined in section 197.020, RSMo, and ambulatory surgical centers (ASCs) as defined in section 197.200, RSMo;

(G) Intensive care unit (ICU) means coronary, medical, surgical, medical/surgical, pediatric, and neonatal intensive care units;

(H) National Healthcare Safety Network (NHSN) means the CDC nosocomial infection surveillance system;

(I) Neonatal intensive care unit (NICU) and high risk nursery (HRN) are synonymous and mean that the infants in those units are critically ill and receive level III care as defined by the CDC;

(J) Nosocomial infection is defined in section 192.665(6), RSMo and is referred to as healthcare-associated infection (HAI) in this rule;

(K) Risk index means grouping patients who have operations according to the American Society of Anesthesiologists (ASA) score, length of procedure, wound class, and other criteria as defined by the CDC for the purpose of risk adjustment as required in section 192.667.3, RSMo;

(L) Surgical site infection (SSI) as defined by the CDC; and

(M) Ventilator-associated pneumonia (VAP) as defined by the CDC.

(2) All hospitals shall submit to the department data to compute HAI infection incidence rates on the following:

(A) CLABs detected in the ICU(s) after June 30, 2005;

(B) SSIs from designated types of surgeries as set forth in section (4) of this rule, detected after December 31, 2005; and

(C) VAPs in the ICU(s) detected after June 30, 2006.

(3) All ASCs shall submit to the department data to compute HAI infection incidence rates on SSIs from designated types of surgeries as set forth in section (5) of this rule, detected after December 31, 2005.

(4) Hospitals shall report SSIs by risk index related to a hip prosthesis, to a Cesarean section, to a coronary artery bypass graft with chest incision only, and to a coronary artery bypass graft with both chest and donor site incisions detected after December 31, 2005.

(5) ASCs shall report SSIs by risk index related to breast surgery and herniorrhaphy detected after December 31, 2005.

(6) In order to be eligible to request a reporting exemption, healthcare providers shall report to the department by March 1, 2005, and every year thereafter the number of central line days and ventilator days in the ICU(s) during the previous calendar year; and the number of surgeries performed as required in sections (4) and (5) during the previous calendar year.

(A) Healthcare providers that had less than fifty (50) central line days in any ICU shall be exempt from reporting CLABs from that ICU for the reporting year starting in July.

(B) Healthcare providers that had less than fifty (50) ventilator days in any ICU shall be exempt from reporting VAPs from that ICU for the reporting year starting in July.

(C) Healthcare providers that had less than twenty (20) surgeries as specified in sections (4) and (5) shall be exempt from reporting the surgery that did not meet the minimum for the reporting year starting in July.

(D) The exemptions shall only apply if the healthcare provider has an infection control program that is in compliance with applicable statutes and regulations of the health facilities regulation unit of the department. The department shall notify the healthcare provider in writing if such provider is exempt from any reporting requirements for the reporting year starting in July.

(7) Healthcare providers may meet the HAI infection reporting requirements if they submit their data to the CDC NHSN or its successor system and if:

(A) All NHSN mandatory data items are submitted to the CDC;

(B) The healthcare provider complies with all NHSN standards and procedures;

(C) The healthcare provider participates in NHSN training provided by the CDC;

(D) The healthcare provider has policies and procedures consistent with appropriate guidelines of CDC, or the Society for Healthcare Epidemiology of America (SHEA), or the Association for Professionals in Infection Control and Epidemiology (APIC) to ensure that all HAI infections as required by this rule are detected and reported;

(E) The healthcare provider has a process to follow up for SSIs a minimum of thirty (30) days after the procedure was performed, and at a minimum review readmission data to identify potential SSIs. Hospitals shall have a system for reporting identified SSIs to the healthcare provider performing the original surgery;

(F) All data are submitted to the NHSN within sixty (60) days of the end of the month;

(G) The healthcare provider participates in a CDC user group that allows the department access to the data, or a data file is generated by the healthcare provider and submitted to the department; and

(H) The healthcare provider shall maintain records related to the information provided to the department for a minimum of two (2) years.

(8) If a healthcare provider chooses to not submit the required data to the CDC NHSN, the healthcare provider may meet the HAI infection reporting requirements by submitting to the department numerator and denominator data on forms provided by the department for each of the infections specified in sections (2), (3), (4), and (5) and if:

(A) The healthcare provider complies with all NHSN standards and procedures;

(B) The healthcare provider participates in NHSN training provided by the CDC;

(C) The healthcare provider has policies and procedures consistent with appropriate guidelines of CDC, or the SHEA, or the APIC to ensure that all HAIs as required by this rule are detected and reported;

(D) The healthcare provider has a process to follow up for SSIs a minimum of thirty (30) days after the procedure was performed, and at a minimum review readmission data to identify potential SSIs. Hospitals shall have a system for reporting identified SSIs to the healthcare provider performing the original surgery;

(E) All data are submitted to the department within sixty (60) days of the end of the month; and

(F) The healthcare provider shall maintain records related to the information provided to the department for a minimum of two (2) years.

(9) The healthcare provider chief executive officer or designee shall annually certify in writing to the department, on a form provided by the department, that the healthcare provider has met all conditions specified in this rule.

AUTHORITY: section 192.667, RSMo Supp. 2004. Original rule filed Feb. 1, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions an annual cost of two hundred fourteen thousand four hundred sixty-five dollars ($214,465) and a one time cost of two hundred fifty-eight dollars ($258) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities an annual cost of three hundred fifty-two thousand one hundred twenty dollars ($352,120) and a one time cost of one thousand two hundred sixty-one dollars ($1,261) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Health and Senior Services, Center for Health Information and Management, Garland Land, Director, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE

Public Cost

I. RULE NUMBER

Rule Number	19 CSR 10-33.050
Type of Rule Making	Proposed

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision:	Estimate of Compliance in the Aggregate
Department of Health and Senior Services-CHIME	$155,816
21Government-Owned Hospitals: Annual Cost One-Time Cost	 $58,649 $258
Total Annual Cost **One-Time Cost**	**$214,465** **$258**

III. WORKSHEET

A. Number of FTE's	Position		Annual Salary
1	Sr.Office Suppt Asst.		$23,684
1	Comp Info Tech II		$41,916
1	Comp Info Tech III		$48,300
1	Research Analyst III		$41,916
		Total Wage	$155,816

B. Government-Owned Hospital Costs

Government-Owned Hospital Costs

Annual Denominator Costs (Costs to Enter Data on Relevant Procedures)

Number of Hospitals That Must Report	Procedure	Total Procedures per Year	Minutes to Input Data per Hospital	Hours/Year: Number of Hospitals X Minutes/60 X 12 Months	Hours/Year: Procedures X Minutes / 60	Total Annual Wages: Hours X $24.26/Hourly Wage
12	Ventilator		300/month	720		$17,467
18	Central Line		300/month	1080		$26,201
9	Hip Replacement	897	5/procedure		74.8	$1,815
2	CBGC	508	5/procedure		42.3	$1,026
2	CBGB	508	5/procedure		42.3	$1,026
16	C-Section	1976	5/procedure		164.7	$3,996
						$51,531

Annual Numerator Costs (Costs to Enter Data on Infections)

Number of Hospitals that must report	Procedure	Total Procedures or Ventilator or Central Line Days per Year	Estimated Infection Rate per 1000 Days or 100 Procedures (Based on CDC Publication)	Infections per Year: Days or Procedures X Infection Rate	Minutes to Input Data per Infection	Hours to Input Data: Infections X Minutes / 60	Total Annual Wages: Hours X $24.26 Hourly Wage
12	Ventilator	22214	6.0 / 1000	133.3	25	55.5	$1,346
18	Central Line	31476	4.0 / 1000	125.9	25	52.5	$1,274
9	Hip Replacement	897	2.05 / 100	18.4	25	7.7	$187
2	CBGC	508	2.76 / 100	14	25	5.8	$141
2	CBGB	508	5.42 / 100	27.5	25	11.5	$279
16	C-Sections	1976	5.45 / 100	107.7	25	44.9	$1,089
							$4,316

One Time/Annual Generic Reporting Requirements

Requirements	Number of Hospitals that must report	Minutes to Input Data per Hospital	Hours/Year: Number of Hospitals X Minutes / 60	Total Annual Wages: Hours X $24.26 Hourly Wage	One Time Costs: Hours X $24.26 Hourly Wage
Facility Contact Information	21	10 (one time)	3.5		$85
Patient Safety Component Hospital Survey	21	30 (annual)	10.5	$255	
Agreement to Participate	21	15 (one time)	5.3		$129
Group Contact Information	21	5 (one time)	1.8		$44
Monthly Reporting Plan	21	300 (annual)	105	$2,547	
				$2,802	**$258**

Total Annual Wages: $51,531+ $4,316+ $2,802: **$58,649**
One-time Costs: **$258**

IV. ASSUMPTIONS

1. That a maximum of 21 government-owned licensed hospitals are affected by the rule during any given year, based on the number of relevant procedures calculated from the 2002 Patient Abstract System of hospital inpatient records.
2. That the number of intensive care units (ICUs) is roughly equal to the number of hospitals.
3. That the primary infection control practitioner is typically a registered nurse with several years experience as a nurse and is sufficiently trained in infection control and reporting procedures. (85% are RN's, 15% are medical technologist, respiratory therapist, LPN's, etc.).
4. That the wage rate, as reported by the Missouri Department of Economic Development (2002-2003 Occupational and Wage Study) remains constant throughout the life of the rule (adjusting 5% annually to account for inflation). Experienced Wage is $24.26 per hour with an annual wage of $50,470.
5. That each affected hospital performs infection control monitoring as part of daily operations.
6. That based on rates published by the Centers for Disease Control (CDC):
    a. The estimated/expected rate for Central Line-associated (CL) Bloodstream Infections (BSI) is 4.0 per 1,000 CL days per hospital.
    b. The estimated/expected rate for Ventilator-associated (VL) Pneumonia is 6.0 per 1,000 VL days per hospital.
    c. The estimated/expected Surgical Site Infection (SSI) rate for Coronary Artery by-pass (CBGC) chest and donor procedures is 5.42 per 100 procedures per hospital.
    d. The estimated/expected SSI rate for Coronary Artery by-pass (CBGC) chest only procedures is 2.76 per 100 procedures per hospital.
    e. The estimated/expected SSI rate for Hip Prosthesis procedures is 2.05 per 100 procedures per hospital.
    f. The estimated/expected SSI rate for Cesarean Section procedures is 5.45 per 100 procedures per hospital.
7. The time spent entering data is the same regardless of whether they are entered into the CDC or MDHSS system.
8. The following table provided by CDC was used to estimate the time involved in completing CDCs National Health Care Safety Network (NHSN) or the MDHSS system for each facility:

Form #	Form Name	Estimated time for response (min.)	Frequency of completion
1	Facility Contact Information	10	1X
2	Patient Safety Component Hospital Survey	30	Yearly
3	Agreement to Participate	15	1X
4	Group contact information	5	Optional
5	Monthly reporting plan	25	Monthly
8	Primary Bloodstream Infection	25	per BSI
9	Pneumonia	25	per Pneumonia (PNU)
11	Surgical Site Infections	25	per SSI
16	Denominators for ICU/other locations	300	per unit/ICU/month
19	Denominator for Procedure	5	each patient undergoing selected procedure

FISCAL NOTE

Private Cost

I. RULE NUMBER

Rule Number	19 CSR 10-33.050
Type of Rule Making	Proposed

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
78	Hospitals: Annual cost One-time cost	$335,257 $946
26	Ambulatory Surgical Centers: Annual cost One-time cost	 $16,863 $315
	Total Annual cost **One-time cost**	**$352,120** **$1,261**

III. WORKSHEET

Annual Denominator Costs (Costs to Enter Data on Relevant Procedures)

Number of Hospitals that must report	Procedure	Total Procedures Per Year	Minutes to Input Data per Hospital per Year	Hours/Year: Number of Hospitals X Minutes / 60 X 12 months	Hours/Year: Procedures X Minutes / 60	Total Annual Wages: Hours X $24.26 Hourly Wage
65	Ventilator		300/month	3900		$94,614
68	Central Line		300/month	4080		$98,981
55	Hip Replacement	6673	5/procedure		556	$13,489
30	CBGC	8955	5/procedure		746.3	$18,105
30	CBGB	8955	5/procedure		746.3	$18,105
54	C-Section	17214	5/procedure		1434.5	$34,801
						$278,095

Annual Numerator Costs (Costs to Enter Data on Infections)

Number of Hospitals that must report	Procedure	Total Procedures or Ventilator or Central Line Days per Year	Estimated Infection Rate per 1000 Ventilator or Central Line Days or 100 Procedures	Infections per Year: Days or Procedures X Infection Rate	Minutes to Input Data/Infection	Hours to Input Data: Infections X Minutes / 60	Total Annual Wages: Hours X $24.26 Hourly Wage
65	Ventilator	276403	6.0 / 1000	1658.4	25	691	$16,764
68	Central Line	289864	4.0 / 1000	1159.4	25	483.1	$11,720
55	Hip Replacement	6673	2.05 / 100	136.8	25	57	$1,383
30	CBGC	8955	2.76 / 100	247.2	25	103	$2,499
30	CBGB	8955	5.42 / 100	485.4	25	202.2	$4,905
54	C-Sections	17214	5.45 / 100	938.2	25	390.9	$9,483
							$46,754

One Time/Annual Generic Reporting Requirements

Requirements	Number of Hospitals that must report	Minutes to Input Data per Hospital	Hours/Year: Number of Hospitals X Minutes / 60	Total Annual Wages:Hours X $24.26 Hourly Wage	One Time Costs: Hours X $24.26 Hourly Wage
Facility Contact Information	78	10 (one time)	13		$315
Patient Safety Component Hospital Survey	78	30 (annual)	39	$946	
Agreement to Participate	78	15 (one time)	19.5		$473
Group Contact Information	78	5 (one time)	6.5		$158
Monthly Reporting Plan	78	300 (annual)	390	$9,461	
				$10,408	**$946**

Total Annual Wages: $278,095 + $46,754 + $10,408: **$335,257**
One-time Costs: **$946**

B.

Ambulatory Surgery Center Costs

Annual Denominator Costs (Costs to Enter Data on Relevant Procedures)

Number of Ambulatory Surg Centers that must report	Procedure	Total Procedures per Year	Minutes to Input Data per ASC per Year	Hours/Year: Procedures X Minutes / 60	Total Annual Wages: Hours X $24.26 Hourly Wage
23	Breast Surgeries	4521	5/procedure	376.8	$9,141
15	Herniorrhaphy	1363	5/procedure	113.6	$2,756
					$11,897

Annual Numerator Costs (Costs to Enter Data on Infections)

Number of Ambulatory Surg Centers that must report	Procedure	Total Procedures per Year	Estimated Infection Rate per 100 procedures (Based on CDC Publication)	Infections per Year: Number of Procedures X Infection Rate	Minutes to Input Data/Infection	Hours to Input Data: Infections X Minutes / 60	Total Annual Wages: Hours X $24.26 Hourly Wage
23	Breast Surgeries	4521	2.16	97.7	25	40.7	$987
15	Herniorrhaphy	1363	3.7	50.4	25	21	$509
							$1,497

One-Time or Annual Generic Reporting Requirements

Requirements	Number of Ambulatory Surg Centers that must report	Minutes to Input Data per ASC	Hours/Year: Number of ASCs X Minutes/60	Total Annual Wages: Hours X $24.26 Hourly Wage	One Time Costs: Hours X $24.26 Hourly Wage
Facility Contact Information	26	10 (one time)	4.3		$104
Patient Safety Component Hospital Survey	26	30 (annual)	13	$315	
Agreement to Participate	26	15 (one time)	6.5		$158
Group Contact Information	26	5 (one time)	2.2		$53
Monthly Reporting Plan	26	300 (annual)	130	$3,154	
				$3,469	**$315**

Total Annul Wages: $11,897 + $1,497 + $3,469: **$16,863** One-time Costs:

IV. ASSUMPTIONS

1. That a maximum of 78 licensed private hospitals and 26 ambulatory surgical centers (ASCs) are affected by the rule during any given year, based on the number of relevant procedures calculated from the 2002 Patient Abstract System of hospital inpatient records.
2. That the number of intensive care units (ICUs) is roughly equal to the number of hospitals.
3. That the primary infection control practitioner is typically a registered nurse with several years experience as a nurse and is sufficiently trained in infection control and reporting procedures. (85% are RN's, 15% are medical technologist, respiratory therapist, LPN's, etc.)
4. That the wage rate, as reported by the Missouri Department of Economic Development (2002-2003 Occupational and Wage Study) remains constant throughout the life of the rule (adjusting 5% annually to account for inflation). Experienced Wage is $24.26 per hour with an annual wage of $50,470.
5. That each affected hospital and ASC performs infection control monitoring as part of daily operations.
6. That based on rates published by the Centers for Disease Control (CDC):
    a. The estimated/expected rate for Central Line-associated (CL) Bloodstream Infections (BSI) is 4.0 per 1,000 CL days per hospital.
    b. The estimated/expected rate for Ventilator-associated (VL) Pneumonia is 6.0 per 1,000 VL days per hospital.
    c. The estimated/expected Surgical Site Infection (SSI) rate for Coronary Artery by-pass (CBGC) chest and donor procedures is 5.42 per 100 procedures per hospital.
    d. The estimated/expected SSI rate for Coronary Artery by-pass (CBGC) chest only procedures is 2.76 per 100 procedures per hospital.
    e. The estimated/expected SSI rate for Hip Prosthesis procedures is 2.05 per 100 procedures per hospital.
    f. The estimated/expected SSI rate for Cesarean Section procedures is 5.45 per 100 procedures per hospital.
    g. The estimated/expected SSI rate for Breast Surgery procedures is 2.16 per 100 procedures per ASC.
    h. The estimated/expected SSI rate for Herniorrhaphy procedures is 3.70 per 100 procedures per ASC.
7. The time spent entering data is the same regardless of whether they are entered into the CDC or MDHSS system.
8. The following table provided by CDC was utilized to estimate the time involved in completing CDC's National Health Care Safety Network (NHSN) or the MDHSS system for each facility:

Form #	Form Name	Estimated time for response (min.)	Frequency of completion
1	Facility Contact Information	10	1X
2	Patient Safety Component Hospital Survey	30	Yearly
3	Agreement to Participate	15	1X
4	Group contact information	5	Optional
5	Monthly reporting plan	25	Monthly
8	Primary Bloodstream Infection	25	per BSI
9	Pneumonia	25	per Pneumonia (PNU)
11	Surgical Site Infections	25	per SSI
16	Denominators for ICU/other locations	300	per unit/ICU/month
19	Denominator for Procedure	5	each patient undergoing selected procedure

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 25—Division of Administration
Chapter 36—Testing for Metabolic Diseases

PROPOSED AMENDMENT

19 CSR 25-36.010 Testing for Metabolic and Genetic Disorders. The department is amending section (6).

PURPOSE: This amendment changes the fee for testing specimens for metabolic and genetic disorders submitted to the State Public Health Laboratory. This amendment is necessary in order to assure that testing for metabolic and genetic disorders is continued at the current level at least through this current fiscal year and for the near future. State law requires that all infants be tested for certain metabolic diseases and other genetic disorders and that such testing be conducted by the State Public Health Laboratory. This amendment increases the fee from twenty-five dollars ($25) to fifty dollars ($50). Laboratory labor costs have risen and there have been additional costs related to improved computer systems and upgraded testing instrumentation. Expanding the number of conditions tested for, as required in the passage of HB 279 in 2001, has added additional costs to the State Public Health Laboratory. An additional cost of approximately twenty-five dollars ($25) has occurred to expand from the previous five (5) conditions to the over twenty-five (25) conditions presently tested for.

(6) *[A]* **Effective July 1, 2005, a** fee of up to *[twenty-five dollars ($25)]* **fifty dollars ($50)** shall be charged for each specimen collection kit **used to obtain the initial blood specimen**. *[Each specimen collection kit represents one (1) specimen. If repeat specimens are required under this rule, the fee shall be charged for each specimen collection kit required to obtain each specimen.]* **If the State Public Health Laboratory recommends repeat specimens, additional specimen collection kits will be made available without the fee being imposed. Repeat specimens requests, other than those recommended by the State Public Health Laboratory, will be subject to the fee and the fee shall be charged for each specimen collection kit required to obtain each repeat specimen.** The Department of Health and Senior Services may collect the fee from any entity or individual described in 191.331.1, RSMo.

*AUTHORITY: sections 701.322, RSMo Supp. [2001] **2004** and 191.331, and 192.006, RSMo 2000. This rule was previously filed as 13 CSR 50-143.010 and 19 CSR 20-36.010. Original rule filed Sept. 29, 1965, effective Oct. 13, 1965. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Feb. 1, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities approximately $2,400,000 annually in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Dr. Eric Blank, State Public Health Laboratory, Department of Health, PO Box 570, Jefferson City, MO 65102, Phone 573/751-3334. To be considered, comments must be received within thirty (30) days after publication in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 19 – Department of Health and Senior Services

Division: 25 – Division of Administration

Chapter: 36 – Testing for Metabolic Diseases

Type of Rule Making: Proposed Amendment

Rule Number and Name: 36.010 – Testing for Metabolic and Genetic Disorders

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimate n the aggregate as to the cost of compliance with the rule by the affected entities.
75,000	Private citizens	$240,000 annually
40	Insurance companies	$2,160,000 annually

III. WORKSHEET

Number of newborns tested – 75,000

Number of samples tested - 96,000

Estimated revenue – 96,000 x $25 = $2,400,000 annually

IV. ASSUMPTIONS

Approximately 75,000 newborns are required to be tested. Some medical providers will elect to test the same child more than once. Based upon FY 04 workload figures, an estimated 96,000 children will be tested that are subject to the increased $25 fee. It is assumed that 90% of the charges will be paid by private health insurance or Medicaid. The remaining 10% will be paid by the private individuals whose child is being tested.

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its Order of Rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the Proposed Rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under section 332.031.3, RSMo 2000, the board amends a rule as follows:

4 CSR 110-2.170 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1514). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under section 332.031.2, RSMo 2000, the board rescinds a rule as follows:

4 CSR 110-2.180 General Anesthesia **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1514). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under section 332.031.2, RSMo 2000, the board rescinds a rule as follows:

4 CSR 110-2.181 Parenteral Conscious Sedation **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1515). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 4—Sedation

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031 and 332.361, RSMo 2000 and 332.071 and 332.362 Supp. 2004, the board adopts a rule as follows:

4 CSR 110-4.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1515–1516). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Dental Board received comments from four (4) commenters on the proposed rule during the comment period.

COMMENT: Dr. Phillip W. Strain commented in opposition to the board's definition of anxiolysis. He questioned the use of any drug that can produce anxiolysis in a patient without the potential to diminish the ability to think, speak or respond. Dr. Strain argues that a drug and dosage which provides anxiolysis in one (1) patient will produce conscious sedation in another patient.
COMMENT: Dr. Alan R. Brown commented that the American Dental Association (ADA), through its Committee on Anesthesia, published its recommended definitions for use by each state board should those bodies choose to establish rules relating to sedation. He

said that according to the ADA's Committee on Anesthesia, the definition of anxiolysis should include, "The administration of a single dose of medication for any given dental appointment, at a dose level no higher than that recommended by the manufacturer for the purpose of obtaining an unsupervised level of reduction in anxiety, sedation or sleep (e.g., at home, or even when out driving a car)."

RESPONSE AND EXPLANATION OF CHANGE: The board spent a tremendous amount of time during the last three (3) years discussing dosing protocols for enteral anxiolysis and sedation, the issue being that varying doses of medication may produce anxiolysis in some patients and sedation in others. Several factors including the patient's weight, medical history, and other medications affect the impact of the drug at a given dosage. The board believes there is no replacement for sound clinical judgment of the attending dentists. However, there are a variety of terms used to describe the different methods of controlling anxiety and pain in dentistry. The definitions used in this rule were taken directly from the American Dental Association's (ADA) *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry*. This publication was amended by the ADA House of Delegates in October of 2003. There is a shortened version of the definition of anxiolysis in this publication that the board overlooked when it began the promulgation of this rule. The intent of the proposed rule is not to prevent dentists from providing care to anxious patients. Under the proposed rule anxiolysis can be accomplished without a permit. If a patient requires sedation, the requirements for an enteral permit have been established for the safety of the patients. The board agrees with Dr. Strain and Dr. Brown and have changed the definition of anxiolysis to its shortened and updated version in subsection (1)(A) of the rule as it is reprinted here. The board does not agree, however, with Dr. Brown to add the additional language after the definition of anxiolysis. The board believes it can regulate the areas of anxiolysis, sedation, and anesthesia via states or levels of sedation rather than by defining dosing protocols. As Dr. Brown indicated in a follow up communication to the board, and the board agrees, these issues can be addressed in the educational curriculums required of permit holders. The board does not agree with Dr. Brown that the rule should contain a definition of "combined anesthesia." By its definition, it is not anxiolysis, but becomes conscious sedation. The board feels its definition of conscious sedation adequately addresses this situation.

COMMENT: The board received one (1) comment from the Missouri Society of Anesthesiologists (MSA) regarding the terminology "conscious sedation" as used in all of the proposed rules. The MSA believes that the board's use of the terminology "conscious sedation" needs to be replaced (or be followed in parentheses in all uses) by moderate sedation/analgesia.

RESPONSE: The board respects the opinion of the MSA but does not believe this change would add to the licensee's understanding of the rule. Conscious sedation is the terminology used in the American Dental Association's *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry* and the same definition adopted by the ADA in its publication is the same used by the board in this proposed rule. Dentists whose patients require conscious sedation use the *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry* as the standard for practice. Because of these reasons, the board feels that the terminology "conscious sedation" is adequately defined in this rule.

COMMENT: Several comments were received regarding the board's definition of nurse anesthetist. The MSA believe that the title "nurse anesthetist" should be just an "advanced practice nurse" as defined in Chapter 335, RSMo. The Missouri State Medical Association (MSMA) believes that the definition should be made more concise by simply requiring that the individual be a certified registered nurse anesthetist recognized as an advanced practice nurse and licensed in accordance with Chapter 335, RSMo. The Missouri Association of Nurse Anesthetists (MoANA) believes that the board's definition is ambiguous because the Missouri State Board of Nursing does not "license" advanced practice nurses such as nurse anesthetists. MoANA says that advanced practice nurses, such as registered nurse anesthetists, apply for "recognition" from the Missouri State Board of Nursing and are granted recognition by such board. They want a more accurate definition that would read "a nurse recognized by the Missouri State Board of Nursing as an advanced practice nurse, who is certified to administer anesthesia by a nationally recognized certifying body approved by the State Board of Nursing in accordance with chapter 335, RSMo."

RESPONSE AND EXPLANATION OF CHANGE: At the time the proposed rule was drafted, the board consulted with the staff of the Missouri State Board of Nursing on the definition of nurse anesthetist and was assured that the final draft definition was appropriate. To use the term "advanced practice nurse" as suggested by MSA would be confusing to the board's licensees. Everyone, including MoANA, refers to the advanced practice nurses who administer anesthesia as nurse anesthetists and the board's licensees know them by either a CRNA or nurse anesthetist title. The board has decided, however, to change the definition and use the term "advanced practice nurse" in the definition and to clarify that the advanced practice nurse has to be licensed by the Missouri State Board of Nursing. The changed definition, subsection (1)(N) of the rule, is reprinted here.

COMMENT: The MSA recommended a change to the definition of "physician anesthesiologist." They feel that the terminology is redundant and stated that by definition, an anesthesiologist is a physician who specializes in the practice of anesthesiology. The MSA recommend that the board change all instances of "physician anesthesiologist" to "anesthesiologist."

RESPONSE AND EXPLANATION OF CHANGE: The board agrees and has changed all references of "physician anesthesiologist," including the definition, to "anesthesiologist." The changed definition, subsection (1)(Q) of the rule, is reprinted here as subsection (1)(A). Additionally, the board will change the reference in the other proposed rules and the appropriate sections will be reprinted in the appropriate orders of rulemaking.

COMMENT: The MSA recommended the addition of a new definition for an "anesthesiologist assistant" and provided a definition from section 334.400, RSMo. The MSMA recommended that the board include anesthesiologist assistants to the list of qualified sedation providers in subsection (1)(S).

RESPONSE: The board disagrees and feels that this could be construed as trying to regulate a healthcare worker outside the board's statutory authority. Under section 334.104.5, RSMo, nurse anesthetists practice "under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available." There is no similar authority for an anesthesiologist assistant with regard to the practice of dentistry that the board is aware of. If an anesthesiologist is providing anesthesia services in a dental office under the board's proposed rules, there is nothing to prevent them from using an anesthesiologist assistant who would be under their supervision and not the supervision of the dentist.

COMMENT: The MoANA recommends that the board remove the term "employed" from the definition of "sedation team" commenting that qualified sedation team members are not usually employees of a dental office. MoANA recommends that the board use a word such as "engaged" or "utilized" to substitute the word "employed" to more accurately reflect the status of qualified sedation team members.

RESPONSE: The board disagrees. *The American Heritage Dictionary* defines employ as "to engage the services of." The board feels that the term employed is appropriately used in the definition and throughout the proposed sedation rules.

4 CSR 110-4.010 Definitions

(1) The following words and terms, when used in this rule, shall have the following meanings.

(A) Anesthesiologist—a physician licensed by the Missouri State Board of Registration for the Healing Arts in accordance with Chapter 334, RSMo, with privileges in general anesthesia at an institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA).

(B) Anxiolysis—the diminution or elimination of anxiety. Anxiolysis is not conscious sedation.

(C) Conscious sedation—a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, and that is produced by a pharmacologic or non-pharmacologic method, or a combination thereof. Conscious sedation is not deep sedation or general anesthesia.

(D) Conscious sedation permit—a document issued by the Missouri Dental Board to a dentist that allows the dentist to administer enteral and/or parenteral conscious sedation.

(E) Conscious sedation site certificate—a document issued by the Missouri Dental Board to a specific dental office where conscious sedation is administered.

(F) Deep sedation—a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to verbal command, and is produced by a pharmacologic or non-pharmacologic method or a combination thereof.

(G) Deep sedation/general anesthesia permit—a document issued by the Missouri Dental Board to a dentist that allows the dentist to administer deep sedation/general anesthesia.

(H) Deep sedation/general anesthesia site certificate—a document issued by the Missouri Dental Board to a specific dental office where deep sedation/general anesthesia is administered.

(I) Dentist-in-charge—a dentist duly licensed by the board to practice at a facility in which sedation anesthesia services are to be offered and who assumes the responsibility to assure that the facility is properly equipped and the sedation team is properly trained.

(J) Dental office—a facility where dentistry is practiced in accordance with the provisions of section 332.071, RSMo.

(K) Dentist—one who is currently licensed to practice as a dentist in Missouri and is ultimately responsible for the sedation procedure of a dental patient under his/her care.

(L) Enteral conscious sedation—a technique of administration in which the drug is absorbed through the gastrointestinal tract or oral mucosa (i.e. oral, rectal, or sublingual). Enteral conscious sedation is not parenteral conscious sedation, deep sedation or general anesthesia.

(M) Facility inspection—an inspection confirming the adequacy of the dental office to provide enteral and/or parenteral conscious sedation by consultants appointed by the board to insure public safety.

(N) General anesthesia—a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including the inability to independently and continuously maintain an airway and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacologic or non-pharmacologic method or a combination thereof.

(O) Nurse anesthetist—a licensed registered professional nurse recognized as an advanced practice nurse by the Missouri State Board of Nursing, who is certified to administer anesthesia by a nationally recognized certifying body approved by the Missouri State Board of Nursing in accordance with Chapter 335, RSMo.

(P) On-site evaluation—a performance evaluation of the competency of the sedation team by consultants appointed by the board to insure public safety.

(Q) Parenteral conscious sedation—a technique of administration in which the drug bypasses the gastrointestinal tract, i.e., routes of administration: intravenous (I.V.), intramuscular (I.M.), intranasal (I.N.), subcutaneous (S.C.), intraoccular (I.O). Parenteral conscious sedation is not deep sedation or general anesthesia.

(R) Sedation team—those individuals qualified pursuant to 4 CSR 110-4.030(7)(B) and employed by the dental office involved with the treatment and/or monitoring of a sedation patient.

(S) Qualified sedation provider—any of the following who have satisfied the provisions of this rule:

1. A currently licensed dentist in Missouri with a valid permit to administer enteral and/or parenteral conscious sedation;
2. A currently licensed anesthesiologist; or
3. A currently licensed nurse anesthetist.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 4—Sedation

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031 and 332.361, RSMo 2000, and 332.071 and 332.362 Supp. 2004, the board adopts a rule as follows:

4 CSR 110-4.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1516–1526). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Dental Board received comments from six (6) commenters on the proposed rule during the comment period. The board did not hold formal hearings following the official comment period. The board began working on the conscious sedation proposed rules in May of 2001. The proposed changes were followed closely by the Missouri Dental Association, the Missouri Association of Nurse Anesthetists, and the Missouri Society of Anesthesiologists. Since May of 2001, the board received a tremendous amount of testimony during the twenty-four (24) committee hearings and/or open board meetings held on the proposed rules.

COMMENT: Although none of the comments received related to section (1), the board discovered an error in this section of the rule during its review process. There is a provision in this section of the rule that exempts dentists from obtaining a conscious sedation permit if prescribing or administering Schedule II drugs for anxiolysis and/or pain control.
RESPONSE AND EXPLANATION OF CHANGE: It was never the intent of the board to require dentists to obtain conscious sedation permits if prescribing a drug such as diazepam, midazolam, and triazolam for anxiolysis or codeine and hydrocodone for pain control. These are Schedule III and IV drugs. Recognizing its error, the board is deleting the term "Schedule II" from section (1) of this rule.

COMMENT: The Missouri Association of Nurse Anesthetists (MoANA) recommend that in section (4) of the rule the board change the word "order" to "request" as it relates to the act of prescribing the anesthesia services.
RESPONSE: The board disagrees that the proper terminology is for the dentist to "request" the anesthesia services. In earlier drafts of the proposed rule the word "prescribe" the anesthesia services was used and the board changed the word to "order" at the suggestion of the MoANA. In the open minutes of the Board's Policy Review Committee meeting on October 24, 2002, testimony was given by

Barbara Holloway, President of the MoANA. At that time, their association objected to only two (2) words in the draft rule. The first word was "prescribe" used in sections (3) and (4) of the draft rule. She said that nurse anesthetists administer and select anesthesia and suggested the word be substituted with either request or order. We agreed on the word "order" at that time. Based on testimony heard by the board, "order" the anesthesia services is the appropriate terminology.

COMMENT: The board received comments from the Missouri State Medical Association (MSMA) and the Missouri Society of Anesthesiologists (MSA) recommending that the board add new language in section (4) of this rule dealing with the supervision of nurse anesthetists. They quote section 334.104, RSMo that requires a nurse anesthetist to work either under a collaborative practice arrangement with a physician or under the supervision of a dentist. They also recommend that language be added that says when the anesthesia provider (a nurse anesthetist or anesthesiologist assistant) is supervised by an anesthesiologist or an anesthesiologist personally performs the anesthetic, anesthesia related medical decision making is performed by the anesthesiologist.

RESPONSE: The board respects the opinion of the MSMA and the MSA and agrees that Missouri law requires a nurse anesthetist to work either under a collaborative practice arrangement with a physician or under the supervision of a dentist but the board does not necessarily agree that it needs to include supervision language in this rule that simply mirrors the statute. Furthermore, the board feels any supervision language would lead to questions about the board's statutory authority to promulgate rules regarding supervision of nurse anesthetists and/or anesthesia assistants as these are not professions licensed or regulated by the Dental Practice Act.

COMMENT: The American Association of Oral and Maxillofacial Surgeons (AAOMS) filed comments and commended the board for proposing additional regulations to provide for the safe administration of analgesia, sedation, and anesthesia in the dental office. The AAOMS notes that the board's proposed regulations are consistent with the AAOMS *Office Anesthesia Evaluation Manual*, with few exceptions. These exceptions include less stringent educational requirements for the administration of enteral conscious sedation than for parenteral conscious sedation. The AAOMS recommends adding language to subsection (5)(A) to require training and competency in maintaining compromised airways.

RESPONSE: The board appreciates the comments received from the AAOMS. The board, however, received a tremendous amount of testimony concerning the educational requirements for enteral permits given in the twenty-four (24) committee hearings and/or open board meetings held on the conscious sedation proposed rules during the last three (3) years. This comment falls into the category expressed by a minority that the educational requirements for enteral and parenteral sedation permits be essentially the same. The majority opinion was that the difficulty of the sedation procedure and the risk to the patient was proportional to the general health status of the patient and the level of sedation and anesthesia administered. Since enteral permit holders are restricted to providing sedation for essentially healthy patients (American Society of Anesthesiologists (ASA) I and II patients) and provide sedation with an extremely low (negligible) risk of compromising the patient's ability to breathe on their own, it was deemed that the educational requirements for enteral permits did not need to be the same as for parenteral permits. Parenteral permit holders may sedate ASA III patients (patients with greater medical compromise) and use an intravenous route of administration that has greater potential for inadvertently inducing a state of sedation in which the patient's breathing may have to be temporarily supported.

COMMENT: The MoANA recommends that section (6) of the rule include programs accredited for nurse anesthetists for postgraduate education to satisfy the requirements for a dentist to obtain a conscious sedation permit.

RESPONSE: The board is aware of only one (1) nurse anesthetist who is also a licensed dentist. That person would qualify for a general anesthesia permit under paragraph (5)(A)1. of the proposed rule 4 CSR 110-4.040 Deep Sedation/General Anesthesia. According to section (14) of this rule, a dentist holding a permit of authorization for the administration of deep sedation/general anesthesia under 4 CSR 110-4.040 may use conscious sedation without a permit for conscious sedation. Therefore, the board does not see the necessity to change the rule.

COMMENT: The AAOMS commented on section (6) of the proposed rule and recommends adding the Commission on Dental Accreditation (CODA) as an accrediting body for postgraduate curriculums which satisfy educational requirements for a parenteral conscious sedation permit.

RESPONSE: The board intentionally left CODA out of the rule for the following reasons. The CODA is the body recognized by the American Dental Association (ADA) for accreditation of undergraduate dental degree programs and postgraduate residency programs. The ADA policy on approval of postgraduate educational requirements for sedation training was, and to some extent still is, under review and in a state of flux. There was testimony at the ADA committee reviewing these guidelines for sedation training that some postgraduate programs that fall outside the purview of CODA should be considered as acceptable training. Should the ADA change its guidelines in the future, the decision to use language "approved or accredited to teach postgraduate dental or medical education by the ADA" would allow the rule to keep up with changes in ADA policy without having to promulgate a revision in the rule.

COMMENT: Dr. Michael J. Hoffman filed comments in opposition to eliminating the four (4) continuous weeks of general anesthesia training for airway management as a requirement for a parenteral conscious sedation permit.

RESPONSE: The proposed rule requires parenteral conscious sedation permit applicants to provide certification in competency of airway management by the course director of an approved postgraduate program teaching sedation. The board is interested in the candidate's skill and competency and has left it up to the educational institutions to determine the structure of their programs.

COMMENT: Dr. Barry Brace filed comments generally in support of the rule with two (2) exceptions. Dr. Brace is concerned that the board did not create a special conscious sedation permit for pediatric sedation. He is also opposed to the requirement in sections (5) and (6) requiring the dentist to complete an Advanced Cardiac Life Support (ACLS) course for enteral and parenteral conscious sedation permits.

RESPONSE: During the course of the twenty-four (24) committee hearings and/or open board meetings held on the conscious sedation proposed rules in the last three (3) years, there was some testimony about the greater risks of pediatric sedation. However, it was the consensus of those that provided testimony that the existing training and site requirements in the proposed rules are adequate and a separate pediatric sedation permit is not necessary to safeguard the public. The board points out that the proposed rule does not require ACLS training. The permit requirements include completion of an ACLS course or fifteen (15) hours of board-approved continuing education pertaining to medical emergencies, anesthesia complications, or patient management while under sedation.

COMMENT: The MSA recommends that the board change the educational requirements to obtain a conscious sedation permit in subsection (6)(B) and other parts of the proposed rule to include an ACLS course and fifteen (15) hours of other board-approved continuing education pertaining to medical emergencies, anesthesia complications, or patient management while under sedation. The proposed rule requires one (1) of three (3) choices to be completed.

RESPONSE: During the course of the twenty-four (24) committee hearings and/or open board meetings held on the conscious sedation proposed rules, there were many hours of arguments about requiring ACLS. The board finally reached a compromise in the current language and it was deemed to be adequate to safeguard the public.

COMMENT: The MoANA recommends that paragraph (7)(A)3. of the proposed rule be clarified to recognize the independent training and licensure of the non-dentist team members and that those team members' credentials do not need to be obtained from one (1) of the board-approved providers. They ask that approved providers of such certification and course work for non-dentists be those approved by their respective licensing authority.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and will amend the rule accordingly.

COMMENT: The MoANA recommends that the word "guidelines" be substituted for the word "protocols" in paragraph (7)(A)5. which requires the dental office to have written protocols for sedation of dental patients to obtain a site certificate.
RESPONSE: The *American Heritage Dictionary* defines protocol as: "A plan for a course of medical treatment." Protocol is exactly the word the board intended to use in this instance.

COMMENT: The MoANA recommends that the board include "post-operative management" to the list of written protocols for sedation of dental patients in subparagraph (7)(A)5.A. requiring preoperative patient evaluation and selection prior to conscious sedation.
RESPONSE: There is a requirement in the proposed rule for a discharge assessment. In the board's proposed rule 4 CSR 110-4.030, there is also the requirement for confirmation of post-discharge supervision and appropriate post-operative instructions. Other post-operative management falls under the purview of the dentist as the provider of care and is not directly related to the sedation/anesthesia.

COMMENT: The MoANA is concerned that the facility inspection requirement in subsection (7)(B) in part is to confirm the competency of the sedation team. They believe that the requirement here and elsewhere in the rule is troublesome because there are no expressed standards of evaluating the competency of the sedation/anesthesia team. They suggest substituting the word "competency" with "credentials" or "qualifications" of the sedation team.
RESPONSE: The board is well within its statutory authority to perform facility inspections to confirm the adequacy of the dental office and to determine the competency of the sedation team. The board has historically called on experts in the field of sedation and anesthesia to perform these functions.

COMMENT: The MSA pointed out a misspelled word in section (18) of the proposed rule. The word is methohexitol. The correct spelling is methohexital.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and will make the correction.

COMMENT: The board received a comment from Nancy Tatum Cardin expressing concern that the proposed rule would prevent dentists from treating extremely anxious patients.
RESPONSE: The proposed rule will not prevent dentists from providing care to anxious patients. Under section (1) of the proposed rule, the treatment of anxiety without sedation can be accomplished without the need for the dentist to obtain a permit. If a patient requires sedation, the requirements for an enteral permit have been established for the safety of patients. The site requirements can be easily met by any licensee and there will be educational opportunities for all dentists to satisfy the requirements of this rule prior to its implementation.

COMMENT: The MSA recommended a change to the definition of "physician anesthesiologist." They feel that the terminology is redundant and stated that by definition, an anesthesiologist is a physician who specializes in the practice of anesthesiology. The MSA recommend that the board change all instances of "physician anesthesiologist" to "anesthesiologist."
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and has changed all references of "physician anesthesiologist," including the definition, to "anesthesiologist." The changed definition, section (4) and subsection (11)(E) of the rule, is reprinted here. Additionally, the board will change the reference in the other proposed rules and the appropriate sections will be reprinted in the appropriate orders of rulemaking.

4 CSR 110-4.020 Conscious Sedation

(1) No dentist shall administer enteral and/or parenteral conscious sedation unless the dentist possesses a conscious sedation permit issued by the Missouri Dental Board. (A dentist is not required to possess a permit for the prescription or administration of drugs prescribed for anxiolysis and/or pain control.) This permit shall be renewed by June 1 every five (5) years from the year of issuance.

(4) If the primary administrator of enteral and/or parenteral conscious sedation in a dental office is an anesthesiologist or a nurse anesthetist, the dentist must order the anesthesia services, is responsible for the readiness of the dental office, preoperative patient evaluation and appropriate medical consultations, the coordination of and emergency preparedness of the sedation team, and the maintenance of appropriate records. The dentist must evaluate the patient prior to the procedure, remain in the dental office, and evaluate the patient prior to discharge.

(7) To qualify for a conscious sedation site certificate:

(A) The dentist-in-charge of the dental office shall document that:

1. The primary administrator of enteral and or parenteral conscious sedation is a qualified sedation provider as set forth in 4 CSR 110-4.010(1)(S);

2. All conscious sedation team members (two (2) minimum) and the dentist, possess and maintain current certification in cardiopulmonary resuscitation (CPR), basic life support (BLS), or ACLS;

3. All conscious sedation team members, including the dentist, possess certification from a board-approved course provider in monitoring conscious sedation. Such certification for non-dentists shall be that approved by their respective licensing authority;

4. The dental office is properly maintained and equipped as set forth in 4 CSR 110-4.030; and

5. The dental office has written protocols for sedation of dental patients as set forth in 4 CSR 110-4.030 including but not limited to the following:

A. Preoperative patient evaluation and selection prior to conscious sedation;

B. Informed consent procedures;

C. Sedation monitoring procedures;

D. Maintaining appropriate records during sedation procedures;

E. Patient discharge assessment; and

F. Responding to emergencies incident to the administration of enteral and/or parenteral conscious sedation.

(11) To renew a site certificate for enteral and/or parenteral conscious sedation the dentist-in-charge shall, at least ninety (90) days prior to the expiration of the current site certificate:

(E) Submit to the board a minimum of five (5) unedited, complete patient records of the permitted dentist, anesthesiologist, or nurse anesthetist administering conscious sedation in the dental office that may be chosen by the board from the preceding five (5) years, documenting management of conscious sedation patients in accordance with the criteria set forth in 4 CSR 110-4.030; and

(12) A dentist holding a current intravenous conscious sedation (IVCS) permit or a parenteral conscious sedation permit on or before the effective date of this rule, shall be authorized to perform all means of parenteral conscious sedation set forth in 4 CSR 110-4.010(1)(Q).

(18) Due to narrow therapeutic dose ranges for conscious sedation, use of thiopental, methohexital, and propofol for conscious sedation of dental patients will be restricted to qualified deep sedation/general anesthesia providers as defined in 4 CSR 110-4.040.

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Division 110—Missouri Dental Board
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ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031 and 332.361, RSMo 2000, and 332.071 and 332.362 Supp. 2004, the board adopts a rule as follows:

4 CSR 110-4.030 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1527–1531). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Dental Board received comments from four (4) commenters on the proposed rule during the comment period. The board did not hold formal hearings following the official comment period. The board began working on the conscious sedation proposed rules in May of 2001. The proposed changes were followed closely by the Missouri Dental Association, the Missouri Association of Nurse Anesthetists, and the Missouri Society of Anesthesiologists. Since May of 2001, the board received a tremendous amount of testimony during the twenty-four (24) committee hearings and/or open board meetings held on the proposed rules.

COMMENT: The Missouri State Medical Association (MSMA) approves this rule and would like to see it duplicated for Deep Sedation/General Anesthesia.
RESPONSE: The board appreciates the comments received from the MSMA. Their comments regarding the American Association of Oral and Maxillofacial Surgeons *Office Anesthesia Evaluation Manual* will be addressed in the order of rulemaking on the Deep Sedation/General Anesthesia rule.

COMMENT: The board received comments from the Missouri Association of Nurse Anesthetists (MoANA) regarding section (4) that requires the American Society of Anesthesiologists (ASA) classifications to be documented and substantiated. They claim that not all ASA classifications are listed and it is unclear whether consideration is given to inside or outside the hospital setting. They are asking for clarification and elaboration of the requirements and to narrow the scope of the restrictions. They question if the board is trying to restrict the nurse anesthetists and anesthesiologists.
RESPONSE: The MoANA claims that the board did not list all ASA classifications but failed to provide the missing classifications. The board has listed the ASA classifications that relate to the dental patient and according to 4 CSR 110-4.030 subsections (4)(B)–(4)(E), a site certificate enables ASA Class I, II, and III dental patients to be sedated in dental outpatient facilities if all other requirements are met.

COMMENT: The MoANA suggests that in paragraph (6)(B)3., the board should change the language "documentation of nothing by mouth" to "documentation of oral intake." They also recommend that in subparagraph (6)(B)4.C. that instead of requiring documentation of vital signs at a minimum of every fifteen (15) minutes throughout the procedure, it be changed to every five (5) minutes.
RESPONSE: The board feels that its licensees are familiar with the term "nothing by mouth" and that the term is normally used in the profession when providing instructions to scheduled sedation patients. Additionally, the standard of care with respect to monitoring vital signs is related to the level of sedation provided. In anxiolysis and light sedation, once every fifteen (15) minutes is the accepted standard. As the level of sedation deepens, the rate of monitoring increases. The standard for moderate and deep sedation is once every five (5) minutes.

COMMENT: The MoANA suggests that paragraph (7)(B)3. of the proposed rule be clarified to recognize the independent training and licensure of the non-dentist team members and that those team members' credentials do not need to be obtained from one of the board-approved providers. They ask that approved providers of such certification and course work for non-dentists be those approved by their respective licensing authority.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and will amend the rule accordingly.

COMMENT: The MoANA suggests that subsections (7)(D) and (7)(E) should be amended to include electrocardiogram (ECG) monitoring.
RESPONSE: The board would agree if this were a hospital and we were dealing with deep sedation of medically compromised patients. However, this rule relates to the conscious sedation of relatively healthy patients. The standard of care for conscious sedation of a relatively healthy patient is not ECG monitoring.

COMMENT: The Missouri Society of Anesthesiologists (MSA) suggests that in subsection (8)(A), the board strike the words "nurse anesthetist" in the sentence that says a dentist may consult with a nurse anesthetist or an anesthesiologist when determining whether a patient is appropriately responsive and stable for discharge. Since the dentist is responsible for supervising a nurse anesthetist, the MSA does not feel consultation is required.
RESPONSE: The board sees no harm in suggesting to its licensees that they may consult with either an anesthesiologist or a nurse anesthetist before making a decision to discharge a patient. There is no requirement in the rule for the consultation.

COMMENT: The MoANA suggests that the board include a requirement in subsection (10)(G) for the availability of a generator or other backup power source for the equipment.
RESPONSE: The board would agree if this were a facility that was performing general anesthesia during which the patient's breathing would have to be supported. However, these patients are consciously sedated, can breathe on their own and many are ambulatory and can walk out with assistance. If power was lost in the facility, patients could be monitored and supported until power was restored or the sedative reversed without any risk to the patient.

COMMENT: The American Association of Oral and Maxillofacial Surgeons (AAOMS) suggest that the board delete paragraph (12)(B)2., making the facility inspection mandatory for all conscious sedation site certificates.
RESPONSE: The board received considerable testimony about documentation of satisfaction of the requirements for site permits and facility inspections. The majority opinion was that the degree of scrutiny of the facility necessary to safeguard the public was proportional to the risk of the sedation. Since enteral permit holders will use lower levels of sedation on essentially healthy patients, affidavits

testifying to satisfaction of the site permit requirements were considered an adequate safeguard. As stated in other responses, the risk of parenteral sedation is greater and, therefore, warrants a facility inspection before issuing a site permit. However, the board retains the right to perform a facility inspection at any site at any time if it deems it necessary to safeguard the public.

COMMENT: The MoANA comments again in section (13) that the board does not have the authority to prescribe the educational requirements for other than its own licensees.
RESPONSE: This section of the rule establishes the criteria for the course work that will satisfy the educational requirements for an enteral conscious sedation permit. This is prescribing the educational requirements for dentists seeking a permit. It does not apply to nurse anesthetists.

COMMENT: The MoANA comments that in paragraph (15)(C)3., the board misspells the drug "labetalol."
RESPONSE AND EXPLANATION OF CHANGE: The board agrees that it misspelled the name of the drug and will correct it accordingly. It should be "labetalol" and not "lobatalol."

COMMENT: The MoANA suggests that the board substitute "anesthesia provider" for "doctor" used in the sample informed consent in section (16).
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and is amending the rule accordingly.

COMMENT: The MSA recommended a change to the definition of "physician anesthesiologist." They feel that the terminology is redundant and stated that by definition, an anesthesiologist is a physician who specializes in the practice of anesthesiology. The MSA recommend that the board change all instances of "physician anesthesiologist" to "anesthesiologist."
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and has changed all references of "physician anesthesiologist," including the definition, to "anesthesiologist." The changed definition, subsections (8)(A) and (9)(A) of the rule, is reprinted here. Additionally, the board will change the reference in the other proposed rules and the appropriate sections will be reprinted in the appropriate orders of rulemaking.

4 CSR 110-4.030 Guidelines for Administration of Conscious Sedation

(7) Monitoring Procedures.

(B) For the purpose of supervising and monitoring a consciously sedated patient, members of the sedation team shall be:

1. Capable of physical assessment of a sedated patient;

2. Certified in Basic Life Support (BLS), Cardiopulmonary Resuscitation (CPR), or Advanced Cardiopulmonary Life Support (ACLS);

3. Certified in monitoring conscious sedation from a board-approved course provider (certification of non-dentists shall be approved by their respective licensing authorities); and

4. Knowledgeable about medical emergency response incident to the use of enteral and parenteral conscious sedation, including the use of resuscitation equipment and emergency medications.

(8) Discharge Assessment and Procedures.

(A) The final responsibility for determining whether a patient is appropriately responsive and stable for discharge rests solely with the dentist. This may be done in consultation with a nurse anesthetist or an anesthesiologist.

(9) Personnel.

(A) The minimum number of individuals available to support a sedated patient shall be three (3): the dentist and two (2) members of the sedation team, which may include a nurse anesthetist or an anesthesiologist.

(12) Site Certificate.

(D) Sedation team members shall be capable of safely executing procedures associated with enteral and/or parenteral conscious sedation. The dentist-in-charge shall verify the following via notarized affidavit:

1. The primary administrator of enteral and/or parenteral conscious sedation is a qualified sedation provider as defined in subsection (1)(S) of 4 CSR 110-4.010 who maintains current certification and licensure in their field of practice;

2. Appropriate patient records are maintained as set forth in section (2) of this rule;

3. Appropriate patient selection criteria are employed as set forth in sections (3) and (4) of this rule. The dentist-in-charge and permitted dentists should be prepared to demonstrate knowledge of physical evaluation of patients, ASA classifications, and their application to appropriate patient selection;

4. Appropriate informed consent is utilized as set forth in section (5) of this rule;

5. Time oriented anesthesia records are appropriately maintained as set forth in section (6) of this rule;

6. Direct and continuous monitoring of sedated patients is accomplished by sedation team members through recovery until discharge as set forth in section (7) of this rule;

7. Appropriate documentation occurs for the management and treatment of sedated patients; and

8. Appropriate criteria are in place to determine when a patient can be safely discharged and appropriate post-operative instructions are given to responsible individuals who will supervise the sedated patient after discharge as set forth in section (8) of this rule.

(15) Emergency Drugs.

(C) Suggested but not required emergency drugs.

1. Aminophylline;
2. Hyperstat or Labetalol (or related drugs);
3. Lidocaine (one hundred (100) mg injectables);
4. Sodium bicarbonate; and
5. Succinylcholine chloride.

(16) Sample Informed Consent for Conscious Sedation.

The purpose of this document is to provide an opportunity for patients to understand and give permission for conscious sedation when provided along with dental treatment. Each item should be checked off after the patient has the opportunity for discussion and questions.

_____1. I understand that the purpose of conscious sedation is to more comfortably receive necessary care. Conscious sedation is not required to provide the necessary dental care. (See #4 options.)

_____2. I understand that conscious sedation is a drug-induced state of reduced awareness and decreased ability to respond. Conscious sedation is not sleep from which I can be easily awakened. My ability to respond normally returns when the effects of the sedative wear off.

_____3. I understand that my conscious sedation will be achieved by the following route:

_____ Oral Administration: I will take a pill approximately _____ minutes before my appointment. The sedation will last approximately ____ to ____ hours. Patients like oral sedation because they do not need an "I.V." line. However the level of sedation is less predictable than with "I.V." sedation.

_____ Intravenous (I.V.) Administration: The anesthesia provider will inject the sedative. The length of sedation may be shorter and the level more predictable than with oral sedation. The I.V. sedation will last approximately ____ to ____ hours.

_____4. I understand that the options to conscious sedation are:

a. No sedation: The necessary procedure is performed under local anesthetic with the patient fully aware.

b. Nitrous oxide sedation: Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally aware of surrounding activities. Its effects can be reversed in five (5) minutes with oxygen.

c. General anesthetic: Commonly called deep sedation, a patient under general anesthetic has no awareness and must have their breathing temporarily supported. General anesthesia is more appropriate for longer procedures lasting three (3) or more hours.

_____5. I understand that there are risks or limitations to all procedures. For sedation these include:

_____(Oral Sedation) Inadequate sedation with initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time. Due to unpredictable patient response, it is not recommended that oral sedatives be given in successive or additive doses.

_____An atypical reaction to sedative drugs that may require emergency medical attention and/or hospitalization.

_____Inability to discuss treatment options with the doctor should the circumstance require a change in treatment plan.

_____6. If, during the procedure, a change in treatment is required, I authorize the dentist and the sedation team to make whatever change they deem in their professional judgment is necessary.

_____7. I have had the opportunity to discuss conscious sedation and have my questions answered by sedation team members including the dentist, if I so desire.

_____8. I hereby consent to conscious sedation in conjunction with my dental care.

_____ _____ _____
Patient/Guardian Date Witness

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 4—Sedation

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031 and 332.361, RSMo 2000, and 332.071, and 332.362 Supp. 2004, the board adopts a rule as follows:

4 CSR 110-4.040 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1531–1541). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Dental Board received comments from six (6) commenters on the proposed rule during the comment period. The board did not hold formal hearings following the official comment period. The board began working on the conscious sedation proposed rules in September 1999. The proposed changes were followed closely by the Missouri Dental Association, the Missouri Association of Nurse Anesthetists, and the Missouri Society of Anesthesiologists. The changes to the deep sedation/general anesthesia rule first appeared in the *Missouri Register* on July 16, 2001. The board received several comments during the comment period, most from nurse anesthetists and the organization that represents nurse anesthetists. The final orders of rulemaking appear to have been filed with the Joint Committee on Administrative Rules (JCAR) on September 28, 2001 but after the JCAR hearing on November 8, 2001, the board withdrew the rule and it was suggested that the board seek a statute change to clarify the board's authority to promulgate rules regarding anesthesia administered in a dental office. During the 2004 session, the anesthesia bill (HB 1422) passed and became effective August 28, 2004.

COMMENT: The Missouri State Medical Association (MSMA) and the Missouri Society of Anesthesiologists (MSA) commented that while 4 CSR 110-4.030 establishes the guidelines for administration of conscious sedation, there are no comparable guidelines in the deep sedation/general anesthesia rule. This rule defers substantially to the American Dental Association's *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry Part II* and the American Association of Oral and Maxillofacial Surgeons' (AAOMS) *Office Anesthesia Evaluation Manual*. The MSMA and the MSA recommend specific guidelines for this rule similar to the guidelines for conscious sedation. The MSMA suggests that perhaps the guidelines for conscious sedation can apply to the deep sedation/general anesthesia rules as well.

RESPONSE AND EXPLANATION OF CHANGE: The board respects and appreciates the comments filed by the MSMA and the MSA to establish specific guidelines for the deep sedation/general anesthesia rules similar to that promulgated for conscious sedation. These comments pointed out an error made by the board when filing the proposed rule. The board failed to include that the AAOMS *Office Anesthesia Evaluation Manual* is incorporated by reference and is on file at the board office. It would be unduly cumbersome to incorporate the entire text of the manual in this rule and to develop new guidelines for this rule would be essentially duplicating the AAMOS manual. Therefore, the board amended the text of the rule to include the incorporation of the AAOMS *Office Anesthesia Evaluation Manual*.

COMMENT: The Missouri Association of Nurse Anesthetists (MoANA) commented on section (4) with basically the same comments on section (4) of 4 CSR 110-4.020. They ask that the word "order" be changed to "request" as it relates to the act of prescribing the anesthesia services.

RESPONSE: The board disagrees that the proper terminology is for the dentist to "request" the anesthesia services. In earlier drafts of the proposed rule the word "prescribe" the anesthesia services was used and the board changed the word to "order" at the suggestion of the MoANA. In the open minutes of the Board's Policy Review Committee meeting on October 24, 2002, testimony was given by Barbara Holloway, President of the MoANA. At that time, their association objected to only two (2) words in the draft rule. The first word was "prescribe" used in sections (3) and (4) of the draft rule. She said that nurse anesthetists administer and select anesthesia and suggested the word be substituted with either request or order. We agreed on the word "order" at that time. Based on testimony heard by the board, "order" the anesthesia services is the appropriate terminology.

COMMENT: The MoANA recommends that subsection (5)(A) of the rule include programs accredited for nurse anesthetists for postgraduate education to satisfy the requirements for a dentist to obtain a deep sedation/general anesthesia permit.

RESPONSE: The board is aware of only one (1) nurse anesthetist who is also a licensed dentist. That person would qualify for a deep sedation/general anesthesia permit under paragraph (5)(A)1. of this rule. Therefore, the board does not see the necessity to change the rule.

COMMENT: The MoANA is concerned that the facility inspection requirement in subsection (6)(C) in part is to confirm the competency of the sedation team. As with the "Conscious Sedation Rule,"

MoANA feels that the term competency is inappropriate and that the word be substituted with either the term "credentials" or "qualifications" of the personnel.
RESPONSE: The board is well within its statutory authority to perform facility inspections to confirm the adequacy of the dental office and to determine the competency of the personnel. The board has historically called on experts in the field of sedation and anesthesia to perform these functions.

COMMENT: The MoANA recommends that in paragraph (6)(D)2. and in subsection (13)(D), the board include the Advanced Cardiac Life Support (ACLS) course as a life support certification option for the dentist and the anesthesia team members as a requirement to obtain and renew a site certificate.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and has corrected both sections accordingly.

COMMENT: Dr. Allan Schwartz recommends that paragraph (5)(A)3. be amended to include, "or a certificate from the Council on Certification of Nurse Anesthetists (CCNA)" so that he may be eligible for a permit to administer deep sedation/general anesthesia without further education and/or training. Dr. Swartz is both a dentist and a nurse anesthetist. Senator-Elect Chuck Graham filed comments with the board in support of Dr. Schwartz.
RESPONSE: Dr. Schwartz qualifies for a deep sedation/general anesthesia permit under paragraph (5)(A)1. of the proposed rule. His nurse anesthetist education would meet the requirements described in Part II of the American Dental Association *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry*. The board does not feel it is necessary to change the rule.

COMMENT: The MSA recommended a change to the definition of "physician anesthesiologist." They feel that the terminology is redundant and stated that by definition, an anesthesiologist is a physician who specializes in the practice of anesthesiology. The MSA recommend that the board change all instances of "physician anesthesiologist" to "anesthesiologist."
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and has changed all references of "physician anesthesiologist," including the definition, to "anesthesiologist." The changed definition, section (4) of the rule, is reprinted here. Additionally, the board will change the reference in the other proposed rules and the appropriate sections will be reprinted in the appropriate orders of rulemaking.

4 CSR 110-4.040 Deep Sedation/General Anesthesia

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(4) If the primary administrator of deep sedation/general anesthesia in a dental office is an anesthesiologist or a nurse anesthetist, the dentist must order the anesthesia services, is responsible for the readiness of the dental office, preoperative patient evaluation and appropriate medical consultations, the coordination of and emergency preparedness of the anesthesia team, and the maintenance of appropriate records. The dentist must evaluate the patient prior to the procedure, remain in the dental office, and evaluate the patient prior to discharge.

(6) To qualify for a deep sedation/general anesthesia site certificate the dental office must—

(A) Be properly equipped in accordance with the American Association of Oral and Maxillofacial Surgeons (AAOMS) *Office Anesthesia Evaluation Manual*, American Association of Oral and Maxillofacial Surgeons, 9700 West Bryn Mawr Avenue, Rosemont, IL 60018-5701, which is incorporated by reference, including but not limited to the capability of delivering positive pressure oxygen, blood pressure and electrocardiographic (ECG) monitoring and pulse oximetry. This rule does not incorporate any subsequent amendments or additions;

(D) The dentist-in-charge of the dental office shall document that:

1. The administrator of deep sedation/general anesthesia is a qualified sedation provider as defined in 4 CSR 110-4.030; and

2. All anesthesia team members, including the operating dentist, possess and maintain current certification in cardiopulmonary resuscitation (CPR), basic life support (BLS), or ACLS.

(13) To renew a site certificate for deep sedation/general anesthesia the dentist-in-charge shall, at least ninety (90) days prior to the expiration of the current site certificate:

(D) Document that anesthesia team members, including the operating dentist, possess and maintain current certification in CPR, BLS, or ACLS; and

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 6—Amusement Rides

ORDER OF RULEMAKING

By the authority vested in the Division of Fire Safety under section 316.206, RSMo 2000, the division amends a rule as follows:

11 CSR 40-6.020 Terms; Defined **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1809–1811). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 6—Amusement Rides

ORDER OF RULEMAKING

By the authority vested in the Division of Fire Safety under section 316.206, RSMo 2000, the division amends a rule as follows:

11 CSR 40-6.025 Exemptions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1812). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 6—Amusement Rides

ORDER OF RULEMAKING

By the authority vested in the Division of Fire Safety under section 316.206, RSMo 2000, the division amends a rule as follows:

11 CSR 40-6.031 Amusement Ride Inspection **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1812–1814). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 6—Amusement Rides

ORDER OF RULEMAKING

By the authority vested in the Division of Fire Safety under section 316.206, RSMo 2000, the division adopts a rule as follows:

11 CSR 40-6.033 Itinerary Required **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1815). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 6—Amusement Rides

ORDER OF RULEMAKING

By the authority vested in the Division of Fire Safety under section 316.206, RSMo 2000, the division amends a rule as follows:

11 CSR 40-6.040 Liability Insurance—Amusement Rides Owner; Required **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1815). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 6—Amusement Rides

ORDER OF RULEMAKING

By the authority vested in the Division of Fire Safety under section 316.206, RSMo 2000, the division amends a rule as follows:

11 CSR 40-6.075 Owner; Maintain Records **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1815). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 6—Amusement Rides

ORDER OF RULEMAKING

By the authority vested in the Division of Fire Safety under section 316.206, RSMo 2000, the division amends a rule as follows:

11 CSR 40-6.080 Operator; Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1816). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 60—Attorney General
Chapter 14—Legal Expense Fund Coverage for Attorneys Practicing Law Without Compensation

ORDER OF RULEMAKING

By the authority vested in the Attorney General pursuant to section 105.711.4, RSMo Supp. 2004, the Attorney General adopts a rule as follows:

15 CSR 60-14.010 Definitions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1557). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Attorney General received one (1) comment on the proposed rule.

COMMENT: John Harl Campbell of Osage Beach commented on behalf of the Missouri Association of Trial Attorneys. He suggests that attorneys in Supreme Court Rule category 6.01(j)(3) should not be excluded from those defined as "licensed attorneys," because of the possibility of, e.g., Kansas or Illinois attorneys volunteering in a qualified organization.

RESPONSE: While attorneys in category 6.01(j)(3) are members of the bar, they represent to the Missouri Supreme Court that they will reside outside of Missouri, and will not be employed in, or practice law in Missouri during the calendar year. As a result they are exempt from certain requirements, e.g., participation in continuing legal education and maintenance of client fund trust accounts. Attorneys in

this category would ordinarily be expected to amend their registration if they engaged in the practice of law in Missouri, whether or not they were compensated for their work. No changes have been made to the rule as a result of this comment.

Title 15—ELECTED OFFICIALS
Division 60—Attorney General
Chapter 14—Legal Expense Fund Coverage for Attorneys Practicing Law Without Compensation

ORDER OF RULEMAKING

By the authority vested in the Attorney General pursuant to section 105.711.4, RSMo Supp. 2004, the Attorney General adopts a rule as follows:

15 CSR 60-14.020 Contract Procedures **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1557). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Attorney General received one (1) comment on the proposed rule.

COMMENT: John Harl Campbell of Osage Beach commented on behalf of the Missouri Association of Trial Attorneys. He proposes to replace subsection (2)(C) with the following: "the attorney does not receive anything of value from any source for his service at the center or agency except, if applicable, compensation derived from his non-center or non-agency practice of law."
RESPONSE: The Attorney General believes the legislature did not intend for the legal expense fund to cover all *pro bono* legal work, only work done without compensation, at or through a nonprofit community social services center or an agency of any federal, state, or local government. Some law firms base attorney compensation, in part, on an appropriate level of *pro bono* service, and as Mr. Campbell points out, some employ attorneys specifically to handle cases for which the firm is not paid. The Attorney General believes the General Assembly intended the term "compensation" in section 105.711 to encompass payments made to or from a third party to the benefit of the attorney, as well as direct payment for services from a client to an attorney. For this reason, the rule purposely excludes attorneys who undertake to do *pro bono* legal work, whether voluntarily or by court assignment, through a traditional law firm or practice, and receive their customary compensation while doing so. No changes have been made to the rule as a result of this comment.

Title 15—ELECTED OFFICIALS
Division 60—Attorney General
Chapter 14—Legal Expense Fund Coverage for Attorneys Practicing Law Without Compensation

ORDER OF RULEMAKING

By the authority vested in the Attorney General pursuant to section 105.711.4, RSMo Supp. 2004, the Attorney General adopts a rule as follows:

15 CSR 60-14.030 Documentation of Legal Practice **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1557–1559). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: There were no comments on the proposed rule.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Environmental Health and Communicable Disease Prevention
Chapter 20—Communicable Diseases

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Health and Senior Services under sections 192.006, 192.020 and 260.203, RSMo 2000, the director amends a rule as follows:

19 CSR 20-20.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2004 (29 MoReg 1733–1734). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Health and Senior Services received three (3) letters of comment on the proposed amendment.

COMMENT: The Missouri Ambulatory Surgery Center Association (MASCA) commented in support of the Division of Environmental Health and Communicable Disease Prevention's (EHCDP) proposed amendment(s) to 19 CSR 20-20.010.
RESPONSE: EHCDP thanks MASCA for reviewing the proposed amendment(s) and for the comment in support of the proposed amendment(s).

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that to be consistent with new Centers for Disease Control and Prevention (CDC) terminology, "nosocomial" should be replaced with "healthcare associated."
RESPONSE: EHCDP declines this proposed change, as the term "nosocomial" is consistent with the language of Senate Bill 1279: Missouri Hospital Infection Control Act of 2004.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that "*Enterococci*" should not be capitalized or italicized.
RESPONSE AND EXPLANATION OF CHANGE: EHCDP agrees with this proposed change.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that *E. gallinarium*, *E. casseliflavus*, and other species of enterococci that are naturally resistant should not be included in the proposed amendment(s).
RESPONSE: EHCDP declines this proposed change, as the inclusion of these species of enterococci in the proposed amendment(s) is consistent with the CDC's definition of vancomycin-resistant enterococci, specifically the enumeration of enterococci that possess intrinsic resistance to vancomycin.

19 CSR 20-20.010 Definitions Relating to Communicable, Environmental and Occupational Diseases.

(26) Methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE), and nosocomial infection are:

(B) VRE shall be defined as enterococci that possess intrinsic or acquired resistance to vancomycin. Several genes, including *van*A, *van*B, *van*C, *van*D, and *van*E, contribute to resistance to vancomycin in enterococci.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Environmental Health and Communicable Disease Prevention
Chapter 20—Communicable Diseases

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Health and Senior Services under sections 192.006, 192.020, 192.139, 210.040 and 210.050, RSMo 2000, the director amends a rule as follows:

19 CSR 20-20.020 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2004 (29 MoReg 1734-1754). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Health and Senior Services received five (5) letters of comment on the proposed amendment.

COMMENT: The Missouri Ambulatory Surgery Center Association (MASCA) commented in support of the Division of Environmental Health and Communicable Disease Prevention's (EHCDP) proposed amendment(s) to 19 CSR 20-20.020.
RESPONSE: EHCDP thanks MASCA for reviewing the proposed amendment(s) and for the comment in support of the proposed amendment(s).

COMMENT: Hilda Chaski of the City of St. Louis Department of Health commented that "Syphilis, including congenital syphilis" should not be changed from a Category I to a Category II reportable disease.
RESPONSE AND EXPLANATION OF CHANGE: In consideration of the information provided in Ms. Chaski's letter of comment, EHCDP agrees with the recommendation that Syphilis should not be changed from a Category I to a Category II reportable disease. "Syphilis, including congenital syphilis" will remain a Category I reportable disease.

COMMENT: Kevin Gipson of the Springfield-Greene County Department of Public Health and Welfare commented that public entity cost estimate to report varicella is incomplete and inaccurate in not taking into account additional data entry of varicella reports into the Missouri Health Surveillance Information System (MOHSIS); and collection of vaccination history and disease/rash severity information that may be necessary to complete those varicella reports that do not contain all required information.
RESPONSE AND EXPLANATION OF CHANGE: EHCDP does not concur that cost of data entry into MOHSIS was not included in the fiscal note. Compliance in reporting varicella will require the reporting of only six (6) data elements, unlike most other reportable diseases/conditions that require expanded data entry. Additionally, EHCDP's original public entity cost estimate included an additional six thousand two hundred fifty-four dollars ($6,254) to report varicella.

EHCDP does concur that there could be added costs due to incomplete and inaccurate data on vaccination history and disease/rash severity. EHCDP has recalculated the fiscal note. Based on the assumption from prior disease reporting that approximately two-thirds of varicella case reports may be incomplete, the collection of a case's vaccination history and disease/rash severity will take an estimated additional twenty (20) minutes per case. Adding twenty (20) minutes of staff time to the original twelve (12) minutes for reporting a case and deleting postage costs, but otherwise using the same methodology as specified in the "FISCAL NOTE WORKSHEET: Public Entity Cost Estimate(s), JULY 2004"; EHCDP estimates a potential additional public entity cost of six thousand three hundred fifteen dollars and eighty-seven cents ($6,315.87) per year to collect data on those two-thirds of the varicella cases that may be incomplete and that are reported through public sources. Therefore, the revised total public entity cost to report varicella is an estimated twelve thousand five hundred sixty-nine dollars and seventy-nine cents ($12,569.79).

COMMENT: Kevin Gipson of the Springfield-Greene County Department of Public Health and Welfare commented that the addition of varicella as a reportable disease brings no discernable benefit to the citizens of Greene County, as his office will not be conducting investigations or implementing interventions.
RESPONSE: EHCDP does not concur. The Council of State and Territorial Epidemiologists (CSTE) recommends case-based varicella surveillance so that public health entities can estimate vaccination coverage and efficacy, provide data for future immunization policy, and allow prompt implementation of disease control measures. For instance, collecting age permits monitoring any shift in varicella incidence to older persons and appropriate targeting of vaccination efforts; collecting vaccination history permits evaluation of the proportion of all cases that are vaccinated (breakthrough); and collecting disease severity permits evaluation of the severity of breakthrough cases and whether severity changes over time. Also, future CDC funding may be contingent on the implementation of varicella surveillance. Missouri's participation in the federal Immunization Grant is important in providing vaccines for Missouri's children. Also, section 192.139, RSMo (Communicable disease reporting, guidelines for department—The communicable disease reporting requirements established by the department of health shall be in accordance with guidelines, funding requirements, or recommendations established by the federal Centers for Disease Control.) mandates that Missouri's reportable conditions mirror the CDC's Nationally Notifiable Disease List (NNDL). Varicella was included in the revised 2004 NNDL, so the addition of varicella to Missouri's reportable conditions is necessary to comply with the NNDL and with Missouri statutes.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that to be consistent with new Centers for Disease Control and Prevention (CDC) terminology, "nosocomial" should be replaced with "healthcare associated."
RESPONSE: EHCDP declines this proposed change, as the term "nosocomial" is consistent with the language of Senate Bill 1279: Missouri Hospital Infection Control Act of 2004.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that "*Enterococci*" should not be capitalized or italicized.
RESPONSE AND EXPLANATION OF CHANGE: EHCDP agrees with the recommendation(s).

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that the numbering in 19 CSR 20-20.020 did not follow a logical order.
RESPONSE: EHCDP declines to make changes in response to this comment. The (sub)section numbering used in 19 CSR 20-20.020 follows the convention(s) used in state rules.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that the "Influenza, laboratory-confirmed" reporting requirement(s) is unclear.
RESPONSE AND EXPLANATION OF CHANGE: EHCDP created a separate reporting category (i.e., Category IIB) for "Influenza, laboratory-confirmed". Diseases/conditions in this category shall be reportable weekly. EHCDP maintains that the four (4) data elements specified in subsection (5)(B), which are necessary to compile accurate aggregate data, comprise an abbreviated case report. The abbreviated case report(s) for "Influenza, laboratory-confirmed" cases provide the requisite information for the weekly aggregate report(s). This resulted in a complete revision to (2)(B) and the addition of a new (2)(C) which was formerly (2)(B).

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) commented that "Influenza, laboratory-confirmed" cases occurring from May to September should be reported as case reports so that seasonal outliers can be tracked.
RESPONSE: EHCDP declines to make changes in response to this comment.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that as written, the proposed amendment would require, at least in larger health care facilities, "whole-house surveillance" which would overburden facilities' infection control resources. As an alternative, staff recommended reporting antibiograms for *Staphylococcus aureus* and enterococci according to the criteria established by the NCCLS.
RESPONSE AND EXPLANATION OF CHANGE: EHCDP agrees with the recommendation. subsection (2)(C) and section (11) of the proposed amendment have been revised to require antibiogram reporting for only those nosocomial methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE) infections that are currently being monitored by each health care facility.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that as written, the proposed amendment does not differentiate between infection and colonization, thus penalizing health care facilities engaged in active surveillance for MRSA and VRE.
RESPONSE AND EXPLANATION OF CHANGE: EHCDP concurs with the recommendation. EHCDP has revised section (11) and subsection (11)(A) of the proposed amendment to require only the reporting of infection-associated isolates.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that as written, the proposed amendment does not clarify if the first diagnostic isolate per quarter or per hospital admission is to be reported.
RESPONSE AND EXPLANATION OF CHANGE: EHCDP concurs with the recommendation. EHCDP has revised section (11) and subsection (11)(B) of the proposed amendment to clarify the requirement to report only a patient's first isolate per hospital admission.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that as written, the proposed amendment is contradictory and confusing as subsection (2)(C) requires the reporting of MRSA and VRE (i.e., resistance), but section (11) and subsection (11)(B) specify the reporting of isolates sensitive to methicillin (etc.) and vancomycin (i.e., susceptibility).
RESPONSE AND EXPLANATION OF CHANGE: EHCDP has revised section (11) and subsection (11)(B) of the proposed amendment to clarify the requirement to report MRSA and VRE in the converse (i.e., by sensitivity/susceptibility). EHCDP declines to further revise this requirement, as most health care facilities affected by the proposed amendment(s) to 19 CSR 20-20.020 currently produce antibiograms in the format of the number of isolates sensitive (or susceptible) over the total number of isolates. Therefore, requiring this format in the proposed amendment will impose less of a reporting burden on the affected health care facilities than would the requirement to report the number of isolates resistant over the total number of isolates.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that a ten (10)-day reporting period after the end of each quarter is not sufficient time to complete laboratory tests and investigations. These staff recommend a thirty (30)-day reporting period after the end of each quarter.
RESPONSE: EHCDP declines to change the length of the end-of-quarter reporting period. However, EHCDP has revised subsection (11)(C) of the proposed amendment to clarify that only those data from a quarter that are available within the ten (10)-day reporting period shall be reported for that quarter.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that the original cost estimate is inaccurate (i.e., a gross underestimate of the actual cost). These staff claim that the provisions of the proposed amendment will require additional infection control staff to investigate patients' medical records for every positive culture of *S. aureus* and enterococci.
RESPONSE: EHCDP declines to change the original cost estimate, which was computed from data voluntarily submitted by a sample of Missouri hospitals. Since EHCDP revised subsection (2)(C) and section (11) to require the reporting of antibiogram data from patients' first diagnostic isolate per admission—exclusive of surveillance isolates—for those body sites currently being monitored by that particular hospital, there should be no increase in hospitals' and ambulatory surgical centers' investigation of positive isolates. Therefore, the only cost incurred by the hospitals and ambulatory surgical centers should be the quarterly reporting of antibiogram data that is currently being collected.

COMMENT: Staff from BJC HealthCare (Diane Hopkins-Broyles, Keith Woeltje, Marilyn Jones, Teresa Garrison) and Barnes-Jewish Hospital (David Warren, Deborah Nihill) commented that all of the private entity cost(s) to report nosocomial MRSA and VRE infections should be assigned to hospitals, so that (hospital and private) laboratories are excluded from the cost estimate.
RESPONSE: Assigning the entire cost associated with the quarterly reporting of antibiograms for MRSA and VRE to hospitals does not change the overall cost estimate. Furthermore, the original fiscal note assumed that the one-half of costs assigned to laboratories would be borne by hospital-associated, not private/independent, laboratories. (NOTE: The "FISCAL NOTE WORKSHEET: Private Entity Cost Estimate(s), JULY 2004" contains an error. The correct private entity cost estimate to report MRSA and VRE is thirty-six thousand eight

hundred sixty-four dollars and forty cents ($36,864.40) annually, not thirty-six thousand six hundred thirty-four dollars and forty cents ($36,634.40). This transcriptional error was not included in the total estimated costs appearing at the bottom of the Private Entity Cost Estimate(s) or the proposed amendment.)

19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases

(1) Category I diseases or findings shall be reported to the local health authority or to the Department of Health and Senior Services within twenty-four (24) hours of first knowledge or suspicion by telephone, facsimile or other rapid communication. Category I diseases or findings are—

(A) Diseases, findings or agents that occur naturally or from accidental exposure:

Animal (mammal) bite wound, humans
Diphtheria
Escherichia coli O157:H7
Escherichia coli, shiga toxin positive, serogroup non-O157:H7
Haemophilus influenzae, invasive disease
Hantavirus pulmonary syndrome
Hemolytic uremic syndrome (HUS), post-diarrheal
Hepatitis A
Influenza—associated public and/or private school closures
Lead (blood) level greater than or equal to forty-five micrograms per deciliter (≥45 μg/dl) in any person equal to or less than seventy-two (≤72) months of age
Measles (rubeola)
Meningococcal disease, invasive
Outbreaks (including nosocomial) or epidemics of any illness, disease or condition that may be of public health concern
Pertussis
Poliomyelitis
Rabies, animal or human
Rubella, including congenital syndrome
Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) Disease
Shiga toxin positive, unknown organism
Shigellosis
Streptococcus pneumoniae, drug resistant invasive disease
Syphilis, including congenital syphilis
Tetanus
Tuberculosis disease
Typhoid fever (*Salmonella typhi*)
Vancomycin-intermediate *Staphylococcus aureus* (VISA), and Vancomycin-resistant *Staphylococcus aureus* (VRSA)

(2) Category II diseases or findings and their reporting requirements are—

(A) Category IIA diseases or findings shall be reported to the local health authority or the Department of Health and Senior Services within three (3) days of first knowledge or suspicion. Category IIA diseases or findings are—

Acquired immunodeficiency syndrome (AIDS)
Arsenic poisoning
Blastomycosis
California serogroup viral encephalitis/meningitis
Campylobacteriosis
Carbon monoxide poisoning
CD4+ T cell count
Chancroid
Chemical poisoning, acute, as defined in the most current ATSDR CERCLA Priority List of Hazardous Substances; if terrorism is suspected, refer to subsection (1)(B)
Chlamydia trachomatis infections
Coccidioidomycosis
Creutzfeldt-Jakob disease
Cryptosporidiosis
Cyclosporiasis
Eastern equine viral encephalitis/meningitis
Ehrlichiosis, human granulocytic, monocytic, or other/unspecified agent
Giardiasis
Gonorrhea
Hansen's disease (Leprosy)
Heavy metal poisoning including, but not limited to, cadmium and mercury
Hepatitis B, acute
Hepatitis B, chronic
Hepatitis B surface antigen (prenatal HBsAg) in pregnant women
Hepatitis B Virus Infection, perinatal
Hepatitis C, acute
Hepatitis C, chronic
Hepatitis non-A, non-B, non-C
Human immunodeficiency virus (HIV)-exposed newborn infant (i.e., newborn infant whose mother is infected with HIV)
Human immunodeficiency virus (HIV) infection, as indicated by HIV antibody testing (reactive screening test followed by a positive confirmatory test), HIV antigen testing (reactive screening test followed by a positive confirmatory test), detection of HIV nucleic acid (RNA or DNA), HIV viral culture, or other testing that indicates HIV infection
Human immunodeficiency virus (HIV) test results (including both positive and negative results) for children less than two (2) years of age whose mothers are infected with HIV
Human immunodeficiency virus (HIV) viral load measurement (including non-detectable results)
Hyperthermia
Hypothermia
Lead (blood) level less than forty-five micrograms per deciliter (<45 μg/dl) in any person equal to or less than seventy-two (≤72) months of age and any lead (blood) level in persons older than seventy-two (>72) months of age
Legionellosis
Leptospirosis
Listeriosis
Lyme disease
Malaria
Methemoglobinemia, environmentally-induced
Mumps
Mycobacterial disease other than tuberculosis (MOTT)
Occupational lung diseases including silicosis, asbestosis, byssinosis, farmer's lung and toxic organic dust syndrome
Pesticide poisoning
Powassan viral encephalitis/meningitis
Psittacosis
Respiratory diseases triggered by environmental contaminants including environmentally or occupationally induced asthma and bronchitis
Rocky Mountain spotted fever
Saint Louis viral encephalitis/meningitis
Salmonellosis
Streptococcal disease, invasive, Group A
Streptococcus pneumoniae, invasive in children less than five (5) years
Toxic shock syndrome, staphylococcal or streptococcal
Trichinosis
Tuberculosis infection
Varicella (Chickenpox)
Varicella deaths
West Nile fever
West Nile viral encephalitis/meningitis
Western equine viral encephalitis/meningitis
Yersiniosis

(B) Category IIB diseases or findings shall be reported directly to the Department of Health and Senior Services weekly. Category IIB diseases or findings are:

Influenza, laboratory-confirmed

(C) Category IIC diseases or findings shall be reported directly to the Department of Health and Senior Services quarterly. Category IIC diseases or findings are:

Methicillin-resistant *Staphylococcus aureus* (MRSA), nosocomial

Vancomycin-resistant enterococci (VRE), nosocomial

(4) A physician, physician's assistant, nurse, hospital, clinic, or other private or public institution providing diagnostic testing, screening or care to any person with any disease, condition or finding listed in sections (1)–(3) of this rule with the exception of methicillin-resistant *Staphylococcus aureus* (MRSA), nosocomial and vancomycin-resistant enterococci (VRE), nosocomial, or who is suspected of having any of these diseases, conditions or findings shall make a case report to the local health authority or the Department of Health and Senior Services, or cause a case report to be made by their designee, within the specified time.

(11) Each hospital and ambulatory surgical center shall report on a quarterly basis antibiogram data for infection, not colonization, from all body sites monitored by that health care facility. Antibiogram data to be reported shall include nosocomial methicillin sensitive *Staphylococcus aureus (S. aureus)*, nosocomial *S. aureus*, nosocomial vancomycin sensitive enterococci, and nosocomial enterococci isolates. Data shall be reported directly to the Department of Health and Senior Services. Reporting shall include only a patient's first diagnostic nosocomial isolate per admission of *Staphylococcus aureus* (*S. aureus*) and enterococci and the isolates corresponding methicillin or vancomycin sensitivity; irrespective of location or of other antimicrobial sensitivity(ies). Intermediate methicillin or vancomycin sensitivity shall be reported as resistant (i.e., methicillin-resistant *Staphylococcus aureus* (MRSA) or vancomycin-resistant enterococci (VRE), respectively).

(A) Isolates from cultures performed for routine surveillance purposes are excluded from the requirement to report. Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE) nosocomial infections to be reported to the Department of Health and Senior Services are limited to those body sites monitored by the individual hospital or ambulatory surgical center.

(B) Aggregate antibiogram data for patients' non-duplicative isolates, per admission, of nosocomial MRSA and VRE infections shall reflect susceptibility patterns and shall be reported as the:

1. Number of nosocomial isolates of *S. aureus* sensitive to methicillin (oxacillin, etc.);
2. Number of nosocomial isolates of *S. aureus*;
3. Number of nosocomial isolates of enterococci sensitive to vancomycin; and
4. Number of nosocomial isolates of enterococci.

(C) Aggregate data shall be reported for the quarters January–March, April–June, July–September, and October–December within ten (10) days of the end of the quarter. Each quarter's aggregate report shall include only those data that are available within a ten (10)-day reporting period from the end of that quarter.

REVISED PUBLIC COST: This proposed amendment may cost state agencies or political subdivisions one hundred thirty-six thousand four hundred thirty-four dollars and fifty-seven cents ($136,434.57) annually in the aggregate, a 4.9% increase from the original cost estimate.

FISCAL NOTE
REVISED PUBLIC ENTITY COST

I. RULE NUMBER

Title: 19 – Department of Health and Senior Services

Division: 20 – Environmental Health and Communicable Disease Prevention

Chapter: 20 – Communicable Diseases

Type of Rule Making: Order

Rule Number and Name: 19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Department of Health and Senior Services	**$123,593.00**
Missouri State Public Health Laboratory	**$6,955.85**
County/district health agencies	**$4,280.52**
Public schools	**$1,605.19**
	Total = $136,434.57

III. WORKSHEET

Allowing an additional 20 minutes of staff time for data collection for approximately two-thirds of the cases typically reported through public sources, but otherwise using the same methodology as specified in the "FISCAL NOTE WORKSHEET: Public Entity Cost Estimate(s), JULY 2004": potential additional public entity cost for varicella reporting is estimated at $6,315.87 per year.

Number of Cases Reported through a Public Entity	Estimated Number of Incomplete Cases	Salary per Reported Case (in Dollars)	Total Salary Costs (in Dollars)
1,616	1,083	$5.83	$6,315.87

The revised total public entity cost to report varicella is an estimated $12,569.79 and the revised total public entity cost for the Proposed Amendement(s) to 19 CSR 20-20.020 is $136,434.57.

IV. ASSUMPTIONS

- Approximately two-thirds of varicella case reports received through public sources may be incomplete.
- For incomplete cases, an additional 20 minutes of staff time may be necessary to collect vaccination history and disease/rash severity.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 19 - Department of Health and Senior Services

Division: 20 - Environmental Health and Communicable Disease Prevention

Chapter: 20 – Communicable Diseases

Type of Rule Making: Proposed

Rule Number and Name: 19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities.
127	Hospitals	$43,561.84
approximately 850	Hospital and private laboratories	$43,819.43
approximately 12,900	Private providers	$2,060.75
approximately 550	Private schools	$1,030.38
	Other/unknown	$2,833.53
		Total – $93,305.93

III. WORKSHEET

See attached Fiscal Note Worksheet: Private Entity Cost Estimate(s), July 2004

IV. ASSUMPTIONS

See attached Fiscal Note Worksheet: Private Entity Cost Estimate(s), July 2004

FISCAL NOTE WORKSHEET:

Private Entity Cost Estimate(s),

JULY 2004

19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases.

PURPOSE: This amendment adds or modifies the requirement to report Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) Disease; Hepatitis B Chronic; Hepatitis B Virus Infection, perinatal; Hepatitis C, acute; Hepatitis C, chronic; Methemoglobinemia, environmentally-induced [modified from Methemoglobinemia]; Methicillin-resistant Staphylococcus aureus (MRSA), nosocomial; Shiga Toxin-Positive, Unknown Organism; Vancomycin-Intermediate Staphylococcus Aureus (VISA); Vancoymcin-resistant Enterococci (VRE), nosocomial; and Varicella (Chickenpox).

Additionally, this amendment corrects the titles of Campylobacteriosis; Cyclosporiasis; Hansen's Disease; Influenza-associated Public and/or Private School Closures; Listeriosis; Outbreaks (including Nosocomial) or Epidemics of Any Illness, Disease or Condition of Public Health Concern; and Yersiniosis.

Finally, this amendment moves the category "Nosocomial Outbreaks" into the category "Outbreaks".

1. **ADDITION OF "SEVERE ACUTE RESPIRATORY SYNDROME-ASSOCIATED CORONAVIRUS (SARS-CoV) DISEASE".**

Assumption: Reporting of this condition by states to the Centers for Disease Control and Prevention (CDC) is critical. As a result, the Missouri Department of Health and Senior Services (MDHSS) places a great deal of emphasis to fully investigate each suspected case of SARS-CoV Disease to avert an immediate danger to the public health, safety or welfare of the citizens of Missouri. Even one case of SARS-CoV Disease is considered an outbreak and significant public health interventions will be applied to any potential case. Taking historical incidence into consideration, the expected number of suspected SARS-CoV Disease cases that would occur annually would be approximately five.

PRIVATE ENTITY COST TO REPORT SARS-CoV DISEASE = **$263.89**. The private entity cost is calculated by: (a) 75% of reports received by MDHSS come from private sources; (b) it takes about 4 hours per case to fill out the questionnaire, interact with local public health agencies/state agencies, and to telephonically report each case – or 4.0 hours of salary of a Community Health Nurse II with a typical salary of $36,960/year ($17.50 hour); and (c) postage of $0.37 to mail each report, which overstates the expense since many will be sent electronically. The private entity cost is:

(c1)	(c2)	(c3)	(c4)	(c5)	(c6)	(c7)
Number of	**4.0 times**	**Total**		**Total**		**Private**

Cases per Year	the Hourly $ Rate	Salary Expense	Postage Rate	Postage Rate	Total Expense	Entity Expense
		= c1 x c2		= c1 x c4	= c3 + c5	= .75 * c6
5	$70.00	$350.00	0.37¢	$1.85	$351.85	$263.89

2. ADDITION OF "HEPATITIS B, CHRONIC".
Assumption(s): Hepatitis B is a serious disease caused by a virus that attacks the liver. The virus, which is called hepatitis B virus, can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. Hepatitis B vaccine is available for all age groups to prevent hepatitis B virus infection. In 2003, the CDC added Hepatitis B, Chronic to its list of nationally notifiable diseases.

The Office of Surveillance (OoS) estimates that there would be approximately 155 reportable cases of Hepatitis B, Chronic. This estimate was arrived at by taking assuming that 1.98% of the estimated 78,000 new cases of acute Hepatitis B will occur in Missouri, for 1,551 Missouri cases. [NOTE: In 2000, Missouri's population (5,595,211) was 1.98% of the national total (281,421,906). The 78,000 estimate is from the Centers for Disease Control and Prevention (CDC).] Of acute Hepatitis B cases, the Hepatitis B Foundation estimates that 90% of cases in infants (<1 year) will become chronic, 50% of cases in children (1-17 years), and 10% of cases in adults (18+ years). In 2003, almost all cases of chronic Hepatitis B reported to the Missouri Health Surveillance Information System (MOHSIS) were in adults. Assuming this age distribution will generally continue, OoS estimates that 10% of the estimated 1,551 annual cases of acute Hepatitis B in Missouri will become chronic, for an estimated total of 155 new cases of chronic Hepatitis B each year. [NOTE: From 2003 onwards, approximately 120 annual cases of chronic Hepatitis B have already been reported using MOHSIS.]

In general, approximately 25% of communicable disease reports received by the MDHSS come from public sources; such as the State Public Health Laboratory, public hospital laboratories, county/district health agencies, and public schools. The remaining 75% of reports come from private sources; such as hospitals, hospital laboratories, private laboratories, private providers, and private schools.

PRIVATE ENTITY COST TO REPORT HEPATITIS B, CHRONIC = **$449.89**. Private entity cost is calculated by: (a) 75% of reports received by MDHSS come from private sources; (b) it takes about 12 minutes to report each case, or 0.2 of the hourly salary of a Community Health Nurse II with a typical salary of $36,960 ($17.50 hour); and (c) postage of $0.37 to mail each report, which overstates the expense since many reports will be sent electronically. The private entity cost is:

(c1)	(c2)	(c3)	(c4)	(c5)	(c6)	(c7)
Number of Cases per Year	**0.2 times the Hourly $ Rate**	**Total Salary Expense**	**Postage Rate**	**Total Postage Rate**	**Total Expense**	**Private Entity Expense**
		= c1 x c2		= c1 x c4	= c3 + c5	= .75 * c6
155	$3.50	$543.00	0.37¢	$57.35	$599.85	$449.89

3. ADDITION OF "HEPATITIS B VIRAL INFECTION, PERINATAL".
Assumption(s): Hepatitis B is a serious disease caused by a virus that attacks the liver. The virus can cause lifelong infection, cirrhosis of the liver, liver cancer, liver failure, and death. Hepatitis B vaccine is available for all age groups to prevent hepatitis B virus infection. During birth, the baby of an infected mother is at risk for hepatitis B virus infection. The risk of perinatal HBV infection among infants born to HBV-infected mothers ranges from 10% to 85%. Infants who become infected by perinatal transmission have a 90% risk of chronic infection, and up to 25% will die of chronic liver disease as adults. Even when not infected during the perinatal period, children of HBV-infected mothers remain at high risk of acquiring chronic HBV infection by person-to-person (horizontal) transmission during the first 5 years of life. More than 90% of these infections can be prevented if HBsAg-positive mothers are identified so that their infants can receive hepatitis B vaccine and hepatitis B immune globulin (HBIG) soon after birth. Infants born to HBV-infected mothers should be given HBIG (hepatitis B immune globulin) and vaccine within 12 hours after birth.

The CDC has recently added Hepatitis B, perinatal disease to its list of nationally notifiable diseases. An estimated 20% of infants born to HBsAg-positive mothers will become infected. In 2003, there were 74 infants born to known Hepatitis B positive mothers in Missouri. Therefore, OoS estimates that there will be 15 or fewer cases of confirmed Hepatitis B virus infection in infants each year in Missouri. [*NOTE: Current reporting of acute and chronic Hepatitis B may include some perinatal Hepatitis B cases, reducing the volume of new reporting required by this proposed rule revision.*]

In general, approximately 25% of communicable disease reports received by the MDHSS come from public sources; such as the State Public Health Laboratory, public hospital laboratories, county/district health agencies, and public schools. The remaining 75% of reports come from private sources; such as hospitals, hospital laboratories, private laboratories, private providers, and private schools.

PRIVATE ENTITY COST TO REPORT HEPATITIS B, PERINATAL INFECTION >/= **$43.54**. Private entity cost is calculated by: (a) 75% of reports received by MDHSS come from private sources; (b) it takes about 12 minutes to report each case, or 0.2 of the hourly salary of a Community Health Nurse II with a typical salary of $36,960 ($17.50 hour); and (c) postage of $0.37 to mail each report, which overstates the expense since many reports will be sent electronically. The private entity cost is:

(c1)	(c2)	(c3)	(c4)	(c5)	(c6)	(c7)
Number of Cases per Year	**0.2 times the Hourly $ Rate**	**Total Salary Expense**	**Postage Rate**	**Total Postage Rate**	**Total Expense**	**Private Entity Expense**
		= c1 x c2		= c1 x c4	= c3 + c5	= .75 * c6
15	$3.50	$53.00	0.37¢	$5.55	$58.05	$43.54

4. CORRECTION OF TITLE TO "HEPATITIS C, ACUTE".
No additional private reporting costs anticipated.

5. CORRECTION OF TITLE TO "HEPATITIS C, CHRONIC".
No additional private reporting costs anticipated.

6. MODIFICATION OF "METHEMOGLOBINEMIA" TO "METHEMOGLOBINEMIA, ENVIRONMENTALLY-INDUCED".
Assumption: Methemoglobinemia is a clinical condition in which more than 1% of hemoglobin in blood has been oxidized to the ferric form. Coma, seizures, and cardiac arrhythmias may occur with methemoglobin levels greater than 55%. Methemoglobinemia may be environmentally-induced, drug-induced, or genetically-induced. The MDHSS is interested in obtaining data for environmentally-induced cases of methemoglobinemia only.

Since 1993, there have been less than ten reported cases of methemoglobinemia due to all causes. Due to low incidence in Missouri, the private costs associated with reporting environmentally-induced methemoglobinemia are negligible.

7. ADDITION OF "METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), NOSOCOMIAL".
Assumption(s): Staphylococcal bacteria (or staph) can cause serious infections, such as surgical wound infections and pneumonia. Treatment of staph infections has become more difficult because the bacteria have become resistant to various antibiotics, such as methicillin.

The "Missouri Nosocomial Infection Control Act of 2004" mandates that nosocomial MRSA infection be included in the list or reportable diseases and/or conditions. The implementation of mandated surveillance activities, specifically the submission of data on nosocomial MRSA infection from health care providers, are required as part of the legislation.

PRIVATE ENTITY COST TO REPORT METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* INFECTION = **$36,864.40**. Private entity cost is calculated by: (a) using a sample of eight Missouri hospitals to estimate the average staff time (in hours), by hospital bedsize (i.e., <50, 50-99, 100-199, 200-299, 300-499, 500+), to report MRSA and VRE; (b) multiplying these bedsize-specific average estimates by the 127 general and children's orthopedic hospitals in Missouri in 2003; (c) multiplying the estimated total reporting time (in hours) by the hourly salary of a Community Health Nurse II with a typical salary of $36,960 ($17.50 hour); and (d) adding postage ($0.37) for each of the hospitals to mail four quarterly reports, which overstates the expense since many reports will be sent electronically. The private entity cost is:

(c1)	(c2)	(c3)	(c4)	(c5)	(c6)	(c7)
Number of Hours per Year	**Hourly Salary Rate, in Dollars**	**Total Salary Expense**	**Postage Rate**	**Total Postage Rate**	**Total Expense**	**Private Entity Expense to Report MRSA**
		= c1 x c2		= c4 x 127 * 4	= c3 + c5	= .50 * c6

4,202.33	$17.50	$73,540.83	0.37¢	$187.96	$73,728.79	$36,864.40

8. ADDITION OF "SHIGA TOXIN-POSITIVE, UNKNOWN ORGANISM".
Assumption(s): Disease caused by Shiga toxin-producing bacteria ranges from self-limiting diarrhea to hemorrhagic colitis and hemolytic uremic syndrome (HUS). Shiga toxin-producing bacteria have been isolated from large foodborne outbreaks, as well as sporadic cases, in North America and abroad.

Based on reporting of non-O157 and unserogrouped E. coli shiga toxin in Missouri for the first quarter of 2004 (n=5 reported confirmed or probable cases), it is estimated that the annual number of reported cases of "shiga toxin-positive, unknown organism" in Missouri will be approximately 20 cases.

PRIVATE ENTITY COST TO REPORT SHIGA TOXIN-POSITIVE, UKNOWN ORGANISM INFECTION >/= **$58.05**. Private entity cost is calculated by: (a) 75% of reports received by MDHSS come from private sources; (b) it takes about 12 minutes to report each case, or 0.2 of the hourly salary of a Community Health Nurse II with a typical salary of $36,960 ($17.50 hour); and (c) postage of $0.37 to mail each report, which overstates the expense since many reports will be sent electronically. The private entity cost is:

(c1)	(c2)	(c3)	(c4)	(c5)	(c6)	(c7)
Number of Cases per Year	**0.2 times the Hourly $ Rate**	**Total Salary Expense**	**Postage Rate**	**Total Postage Rate**	**Total Expense**	**Private Entity Expense**
		= c1 x c2		= c1 x c4	= c3 + c5	= .75 * c6
20	$3.50	$70.00	0.37¢	$7.40	$77.40	$58.05

9. ADDITION OF "VANCOMYCIN-INTERMEDIATE *STAPHYLOCOCCUS AUREUS*" (VISA).
Assumption(s): VISA is a specific type of antimicrobial-resistant staph bacteria. While most staph bacteria are susceptible to the antimicrobial agent vancomycin some have developed resistance. VISA infections are rare. Only eight cases of infection caused by VISA have been reported in the United States. VISA is only part of the larger problem of antimicrobial resistance in healthcare settings. Spread occurs among people having close physical contact with infected patients or contaminated material, like bandages. Strategies that can prevent antimicrobial resistance include diagnose and treat infections effectively; use antimicrobials wisely; and prevent transmission of infections.

Since only eight cases of VISA have been reported nationally, with no state reporting more than one case; it is estimated that the annual number of reported cases of "vancomycin-intermediate *staphylococcus aureus*" (VISA) in Missouri will not exceed three cases. Due to low incidence in Missouri, the private costs associated with reporting this disease are negligible.

10. ADDITION OF "VANCOMYCIN-RESISTANT *ENTEROCOCCI* (VRE), NOSOCOMIAL".

Assumption(s): Enterococci are among the leading causes of nosocomial bacteremia, surgical wound infection, and urinary tract infection. Unfortunately, they are becoming resistant to many and sometimes all standard therapies.

The "Missouri Nosocomial Infection Control Act of 2004" mandates that nosocomial VRE infection be included in the list or reportable diseases and/or conditions. The implementation of mandated surveillance activities, specifically the submission of data on nosocomial VRE infection from health care providers, are required as part of the legislation.

PRIVATE ENTITY COST TO REPORT VANCOMYCIN-RESISTANT *ENTEROCOCCI* INFECTION = **$36,864.40**. Private entity cost is calculated by: (a) using a sample of eight Missouri hospitals to estimate the average staff time (in hours), by hospital bedsize (i.e., <50, 50-99, 100-199, 200-299, 300-499, 500+), to report MRSA and VRE; (b) multiplying these bedsize-specific average estimates by the 127 general and children's orthopedic hospitals in Missouri in 2003; (c) multiplying the estimated total reporting time (in hours) by the hourly salary of a Community Health Nurse II with a typical salary of $36,960 ($17.50 hour); and (d) adding postage ($0.37) for each of the hospitals to mail four quarterly reports, which overstates the expense since many reports will be sent electronically. The private entity cost is:

(c1)	(c2)	(c3)	(c4)	(c5)	(c6)	(c7)
Number of Hours per Year	**Hourly Salary Rate, in Dollars**	**Total Salary Expense**	**Postage Rate**	**Total Postage Rate**	**Total Expense**	**Private Entity Expense to Report VRE**
		= c1 x c2		= c4 x 127 * 4	= c3 + c5	= .50 * c6
4,202.33	$17.50	$73,540.83	0.37¢	$187.96	$73,728.79	$36,864.40

11. ADDITION OF "VARICELLA (CHICKENPOX)".

Assumption(s): The Centers for Disease Control and Prevention (CDC) have urged states to track morbidity of Varicella. Additionally, to be eligible for the CDC's Immunization Grant Funding in FY 2005, Varicella must be a reportable condition. The number of potential cases that would occur annually was calculated by taking the number of Missouri births in 2002[1] and multiplying it by the Varicella birth cohort found on CDC's website[2] using the last year (1997) that statistical comparisons were available for Missouri (75,167 births x 8.6% = **6,464 cases** of Varicella).

PRIVATE ENTITY COST TO REPORT VARICELLA = **$18,761.76**. The private entity cost is calculated using by: (a) 75% of reports received by MDHSS come from private sources; (b) it takes about 12 minutes to report each case, or 0.2 of the hourly salary of a Community Health Nurse II with a typical salary of $36,960/year ($17.50 hour); and (c) postage of $0.37 to mail

[1]MDHSS MICA. http://www.dhss.state.mo.us/MVS02/Table05a.pdf
[2] CDC. http://www.cdc.gov/mmwr/preview/mmwrhtml/00056339.htm#00001948.gif

each report, which overstates the expense since many will be sent electronically. The private entity cost is:

(c1)	(c2)	(c3)	(c4)	(c5)	(c6)	(c7)
Number of Cases per Year	**0.2 times the Hourly $ Rate**	**Total Salary Expense**	**Postage Rate**	**Total Postage Rate**	**Total Expense**	**Private Entity Expense**
		= c1 x c2		= c1 x c4	= c3 + c5	= .75 * c6
6,464	$3.50	$22,624	0.37¢	$2,391.68	$25,015.68	$18,761.76

12. CORRECTION OF TITLE TO "CAMPYLOBACTERIOSIS".
No additional private reporting costs anticipated.

13. CORRECTION OF TITLE TO "CYCLOSPORIASIS".
No additional private reporting costs anticipated.

14. CORRECTION OF TITLE TO "HANSEN'S DISEASE (LEPROSY)".
No additional private reporting costs anticipated.

15. CORRECTION OF TITLE TO "INFLUENZA-ASSOCIATED PUBLIC AND/OR PRIVATE SCHOOL CLOSURES".
No additional private reporting costs anticipated.

16. CORRECTION OF TITLE TO "LISTERIOSIS".
No additional private reporting costs anticipated.

17. CORRECTION OF TITLE TO "OUTBREAKS (INCLUDING NOSOCOMIAL) OR EPIDEMICS OF ILLNESS, DISEASE OR CONDITION OF PUBLIC HEALTH CONCERN".
No additional private reporting costs anticipated.

18. CORRECTION OF TITLE TO "YERSINIOSIS".
No additional private reporting costs anticipated.

19. DELETION OF "NOSOCOMIAL OUTBREAKS" AS AN INDIVIDUAL REPORTABLE CATEGORY.
No additional or decreased private reporting costs anticipated.

TOTAL PRIVATE ENTITY COSTS:

$263.89 + $449.89 + $43.54 + $36,864.40 + $58.05 + $36,864.40 + $18,761.76 = $93,305.93

Table. Distribution of Total Private Entity Cost(s), by Affected Agency or Political Subdivision

Affected Agency or Political Subdivision	Portion, or Fraction, of Total Costs	Estimated Cost of Compliance
Hospitals	1/2 of MRSA/VRE reporting and 26/76 of remaining costs	$43,561.84
Hospital & private laboratories	1/2 of MRSA/VRE reporting and 27/76 of remaining costs	$43,819.43
Private providers	8/76 of remaining costs	$2,060.75
Private schools	4/76 of remaining costs	$1,030.38
Other/unknown	11/76 of remaining costs	$2,833.53

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs and other items required to be published in the *Missouri Register* by law.

Title 7—DEPARTMENT OF TRANSPORTATION
Division 10—Missouri Highways and Transportation Commission
Chapter 25—Motor Carrier Operations

IN ADDITION

7 CSR 10-25.010 Skill Performance Evaluation Certificates for Commercial Drivers

PUBLIC NOTICE

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

SUMMARY: This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates, from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce, because of impaired vision, or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

DATES: Comments must be received at the address stated below, on or before March 31, 2005.

ADDRESSES: You may submit comments concerning an applicant, identified by the Application Number stated below, by any of the following methods:
• *E-mail: Kathy.Hatfield@modot.mo.gov*
• *Mail: PO Box 893, Jefferson City, MO 65102-0893*
• *Hand Delivery: 1320 Creek Trail Drive, Jefferson City, MO 65109*
• *Instructions:* All comments submitted must include the agency name and Application Number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

COMMENTS RECEIVED BECOME MoDOT PUBLIC RECORD

• By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
• *Docket:* For access to the department's file, to read background documents or comments received, 1320 Creek Trail Drive, Jefferson City, MO 65109, between 7:30 a.m. and 4 p.m., Monday through Friday, except state holidays.

FOR FURTHER INFORMATION CONTACT: Ms. Kathy Hatfield, Motor Carrier Specialist, (573) 522-9001, MoDOT Motor Carrier Services Division, PO Box 893, Jefferson City, MO 65102-0893. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

SUPPLEMENTARY INFORMATION:

Public Participation
If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

Background
The individuals listed in this notice have recently filed applications requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10), or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, *Missouri Revised Statutes* (RSMo) Supp. 2002, MoDOT may issue a Skill Performance Evaluation Certificate, for not more than a two (2)-year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing a SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

Qualifications of Applicants

Application # MP040715052

Applicant's Name & Age: Ronald Keith Dunnavant, 37
Relevant Physical Condition: Mr. Dunnavant's best corrected visual acuity in his right eye is 20/20 Snellen and he has congenital strabismic amblyopia in his left eye (lazy left eye). In his left eye, uncorrected visual acuity is 20/200 Snellen.
Relevant Driving Experience: Employed by Ameren UE as a gas laborer, pipe fitter and equipment operator from July 2002 to present and has driven 1 hour per day, to and from the job site and headquarters. Employed as a pipe fitter for the City of Fulton, gas department from August 1986 to 2002. Drives personal vehicle(s) daily.
Doctor's Opinion & Date: Following an examination in July 2004, his optometrist certified, "In my medical opinion, Mr. Dunnavant's visual deficiency is stable and has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and that his condition will not adversely affect his ability to operate a commercial motor vehicle safely."
Traffic Accidents and Violations: No accidents or violations within the past 3 years.

Request for Comments.
The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: February 1, 2005

Jan Skouby, Motor Carrier Services Director, Missouri Department of Transportation.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 12—Liquor Control

IN ADDITION

A proposed amendment to 11 CSR 45-12.020 was published in the *Missouri Register* on July 1, 1994 (19 MoReg 1541) and a final order of rulemaking was published in the *Missouri Register* on December 1, 1994 (19 MoReg 2872–2873). An error in punctuation in section (1) occurred when published in the *Code of State Regulations*. A comma was inadvertently omitted in the sentence ". . . Class A applicant or licensee to serve, offer for sale . . ." This rule appeared correctly in the February 28, 2005 update to the *Code of State Regulations*.

Section (1) is reprinted here in its entirety for clarification.

11 CSR 45-12.020 Excursion Liquor License Defined

(1) As used in this chapter, the term excursion liquor licensee shall mean any Class A applicant or licensee who has been issued an excursion liquor license which authorizes the Class A applicant or licensee to serve, offer for sale or sell intoxicating liquor aboard any excursion gambling boat or facility immediately adjacent to and contiguous with the excursion gambling boat which is owned and operated by the Class A applicant or licensee.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 12—Liquor Control

IN ADDITION

A proposed rule, 11 CSR 45-12.090, was published in the *Missouri Register* on September 17, 1993 (18 MoReg 1749) and a final order of rulemaking was published in the *Missouri Register* on December 17, 1993 (18 MoReg 2487–2488). A phrase in subsections (6)(A) and (6)(B) has been incorrectly published in the *Code of State Regulations*. The text in these subsections should read ". . . his/her or its officers, . . ." A typographical error has occurred in subsection (9)(D). The text should read ". . . of the merchandise to the wholesaler and all federal . . ." A phrase in section (16) has been incorrectly published in the *Code of State Regulations*. The text in this section should read ". . . or supplied by him/her as a beverage . . ." This rule appeared correctly in the February 28, 2005 update to the *Code of State Regulations*.

Subsections (6)(A), (6)(B) and (9)(D) and section (16) are reprinted here in their entirety for clarification.

11 CSR 45-12.090 Rules of Liquor Control

(6) Purchase of Intoxicating Liquor. An excursion liquor licensee may purchase intoxicating liquor only from a wholesale liquor dealer duly licensed by the Missouri Supervisor of Liquor Control. No excursion liquor licensee or any of his/her/its employees or agents, shall—

(A) Offer or give an order for such intoxicating liquor to a person licensed as a manufacturer (distiller or wine maker) or solicitor of intoxicating liquor containing alcohol or any of his/her or its officers, directors, employees, agents or representatives; and

(B) Call upon, contact or meet at places other than the retailer's place of business with the manufacturers or solicitors of any of his/her or its officers, directors, employees, agents or representatives for any purpose in any way connected with or related to intoxicating liquor by any means or place.

(9) Retailers Shall Accept Only Ordinary Credit—May Supply Retailers with Following Items. No excursion liquor licensee, directly or indirectly, shall accept any loans, equipment, money, credit or property of any kind, except ordinary commercial credit. No excursion liquor licensee shall permit any distiller, wholesaler, wine maker, brewer or his/her/its employees, officers or agents, under any circumstances, directly or indirectly, to have any financial interest in his/her/its retail business for the sale of intoxicating liquor and s/he/it shall not accept, directly or indirectly, from a distiller, wholesaler, wine maker, brewer or its employees, officers or agents any loan, gifts, equipment, money, credit or property of any kind except ordinary commercial credit for intoxicating liquor sold to the licensee.

(D) Defining the word cost. The word cost as used in this rule shall mean the actual charge for the merchandise in question by the supplier of the merchandise to the wholesale, plus the cost of transportation of the merchandise to the wholesaler and all federal and Missouri excise taxes and custom duties allocable to the merchandise.

(16) Adulteration. No excursion licensee, through actions of his/her/its own or of an employee, for any purpose whatsoever may mix, or permit, or cause to be mixed with any intoxicating liquor kept for sale, sold or supplied by him/her as a beverage, any drug or form of methanol alcohol or impure form of alcohol.

Title 20—DEPARTMENT OF INSURANCE

IN ADDITION

Pursuant to section 538.210, RSMo 2000 regarding the medical malpractice award limit, the director of insurance is required to calculate the new limitation for non-economic damages in medical malpractice awards.

Using the Implicit Price Deflator (IPD) for Personal Consumption Expenditures (PCE), as required by section 538.210, RSMo 2000, the new limit was established by the following calculations:

Index Based in 2000 Dollars	
Fourth Quarter 2004 IPD Index	108.67
Fourth Quarter 2003 IPD Index	106.00

New Limit = 2004 Limit × (2004 Index/2003 Index)
579,388 = 565,153 × (1.0867/1.0600)

2005 Non-Economic Damages Limit (Rounded) = $579,000

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000 to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript.

NOTICE OF CORPORATE DISSOLUTION

To All Creditors of and Claimants Against R-F Holding Company:

On December 13, 2004, R-F Holding Company, a Missouri corporation, filed its Articles of Dissolution with the Missouri Secretary of State. The dissolution was effective on the 13th day December, 2004.

Said corporation request that all persons and organizations who have claims against it present them immediately by letter to the corporation, c/o Diane Hook, Esq., P.O. Box 364, St. Joseph, Missouri 64501,

All claims must include: the name, address, and telephone number of the claimant, the amount claimed, the basis for the claim, the date(s) on which the event(s) on which the claim is based occurred, and whether the claim is secured, and if so, a description of the collateral.

Because of the dissolution of R-F Holding Company, any claims against it will be barred unless a proceeding to enforce the claim is commenced within two years after the publication of the notices authorized by statute.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—27 (2002), 28 (2003), 29 (2004) and 30 (2005). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				27 MoReg 189 27 MoReg 1724 28 MoReg 1861 29 MoReg 1610
1 CSR 10-4.010	Commissioner of Administration		28 MoReg 1557	29 MoReg 2320	30 MoReg 320
1 CSR 20-1.010	Personnel Advisory Board and Division of Personnel		30 MoReg 148		
1 CSR 20-3.010	Personnel Advisory Board and Division of Personnel		30 MoReg 148		
1 CSR 20-3.020	Personnel Advisory Board and Division of Personnel		30 MoReg 149		
1 CSR 20-3.070	Personnel Advisory Board and Division of Personnel		29 MoReg 1513	30 MoReg 384	
1 CSR 20-5.025	Personnel Advisory Board and Division of Personnel		29 MoReg 1513	30 MoReg 384W	
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.010	Animal Health	29 MoReg 1417 30 MoReg 139	29 MoReg 1437 30 MoReg 149	30 MoReg 187	
2 CSR 30-6.020	Animal Health	29 MoReg 1418	29 MoReg 1438	30 MoReg 187	29 MoReg 1480
2 CSR 30-10.010	Animal Health		29 MoReg 2257		
2 CSR 30-22.010	Animal Health		29 MoReg 2257		
2 CSR 70-40.015	Plant Industries		29 MoReg 1439	30 MoReg 301	
2 CSR 70-40.025	Plant Industries		29 MoReg 1439	30 MoReg 301	
2 CSR 100-7.010	Missouri Agricultural and Small Business Development Authority		30 MoReg 150		
2 CSR 100-10.010	Missouri Agricultural and Small Business Development Authority		30 MoReg 151		
	DEPARTMENT OF CONSERVATION				
3 CSR 10-3.010	Conservation Commission		29 MoReg 1689	30 MoReg 187	
3 CSR 10-4.110	Conservation Commission		29 MoReg 1689	30 MoReg 187	
3 CSR 10-4.111	Conservation Commission		29 MoReg 1690	30 MoReg 188	
3 CSR 10-4.113	Conservation Commission		29 MoReg 1690	30 MoReg 188	
3 CSR 10-5.205	Conservation Commission		29 MoReg 1690	30 MoReg 188	
3 CSR 10-5.215	Conservation Commission		29 MoReg 1691	30 MoReg 188	
3 CSR 10-5.225	Conservation Commission		29 MoReg 1691	30 MoReg 188	
3 CSR 10-5.430	Conservation Commission		29 MoReg 1691	30 MoReg 188	
3 CSR 10-5.565	Conservation Commission		29 MoReg 1692	30 MoReg 188	
3 CSR 10-5.579	Conservation Commission		29 MoReg 1692	30 MoReg 189	
3 CSR 10-6.410	Conservation Commission		29 MoReg 1692 This Issue	30 MoReg 189	
3 CSR 10-6.415	Conservation Commission		29 MoReg 1692	30 MoReg 189	
3 CSR 10-6.505	Conservation Commission		29 MoReg 1793	30 MoReg 301	
3 CSR 10-6.510	Conservation Commission		29 MoReg 1693	30 MoReg 189	
3 CSR 10-6.511	Conservation Commission		N.A.	30 MoReg 301	
3 CSR 10-6.525	Conservation Commission		29 MoReg 1693	30 MoReg 189	
3 CSR 10-6.533	Conservation Commission		29 MoReg 1694	30 MoReg 189	
3 CSR 10-6.535	Conservation Commission		29 MoReg 1694	30 MoReg 190	
3 CSR 10-6.605	Conservation Commission		29 MoReg 1695	30 MoReg 190	
3 CSR 10-6.610	Conservation Commission		29 MoReg 1695	30 MoReg 190	
3 CSR 10-6.615	Conservation Commission		29 MoReg 1696	30 MoReg 190	
3 CSR 10-7.410	Conservation Commission		29 MoReg 1696	30 MoReg 190	
3 CSR 10-7.427	Conservation Commission		29 MoReg 1696	30 MoReg 191	
3 CSR 10-7.430	Conservation Commission		29 MoReg 1793	30 MoReg 304	
3 CSR 10-7.431	Conservation Commission		29 MoReg 1697	30 MoReg 191	
3 CSR 10-7.438	Conservation Commission		29 MoReg 1794	30 MoReg 304	
3 CSR 10-7.455	Conservation Commission		29 MoReg 1697 N.A.	30 MoReg 191 30 MoReg 304	30 MoReg 321
3 CSR 10-8.510	Conservation Commission		29 MoReg 1697	30 MoReg 191	
3 CSR 10-8.515	Conservation Commission		29 MoReg 1698	30 MoReg 191	
3 CSR 10-9.105	Conservation Commission		29 MoReg 1698	30 MoReg 191	
3 CSR 10-9.110	Conservation Commission		29 MoReg 1794	30 MoReg 304	
3 CSR 10-9.220	Conservation Commission		29 MoReg 1699	30 MoReg 192	
3 CSR 10-9.240	Conservation Commission		29 MoReg 1699	30 MoReg 192	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
3 CSR 10-9.425	Conservation Commission		29 MoReg 1699	30 MoReg 192	
3 CSR 10-9.440	Conservation Commission		29 MoReg 1700	30 MoReg 192	
3 CSR 10-9.566	Conservation Commission		29 MoReg 1700	30 MoReg 192	
3 CSR 10-9.570	Conservation Commission		29 MoReg 1700	30 MoReg 192	
3 CSR 10-9.575	Conservation Commission		29 MoReg 1701	30 MoReg 193	
3 CSR 10-9.625	Conservation Commission		29 MoReg 1701	30 MoReg 193	
3 CSR 10-10.705	Conservation Commission		29 MoReg 1701	30 MoReg 193	
3 CSR 10-10.725	Conservation Commission		29 MoReg 1702	30 MoReg 193	
3 CSR 10-10.732	Conservation Commission		29 MoReg 1702	30 MoReg 193	
3 CSR 10-11.120	Conservation Commission		29 MoReg 1703	30 MoReg 194	
3 CSR 10-11.125	Conservation Commission		29 MoReg 1703	30 MoReg 194	
3 CSR 10-11.145	Conservation Commission		29 MoReg 1703	30 MoReg 194	
3 CSR 10-11.150	Conservation Commission		29 MoReg 1704	30 MoReg 194	
3 CSR 10-11.155	Conservation Commission		29 MoReg 1704	30 MoReg 194	
3 CSR 10-11.180	Conservation Commission		29 MoReg 1795	30 MoReg 305	
3 CSR 10-11.182	Conservation Commission		29 MoReg 1797	30 MoReg 305	
3 CSR 10-11.183	Conservation Commission		29 MoReg 1799R	30 MoReg 305R	
3 CSR 10-11.186	Conservation Commission		29 MoReg 1704	30 MoReg 194	
3 CSR 10-11.187	Conservation Commission		29 MoReg 1705	30 MoReg 195	
3 CSR 10-11.205	Conservation Commission		29 MoReg 1705	30 MoReg 195	
3 CSR 10-11.210	Conservation Commission		29 MoReg 1706	30 MoReg 195	
3 CSR 10-11.215	Conservation Commission		29 MoReg 1707	30 MoReg 195	
3 CSR 10-12.109	Conservation Commission		29 MoReg 1707	30 MoReg 195	
3 CSR 10-12.110	Conservation Commission		29 MoReg 1799	30 MoReg 305	
3 CSR 10-12.115	Conservation Commission		29 MoReg 1800	30 MoReg 305	
3 CSR 10-12.125	Conservation Commission		29 MoReg 1800	30 MoReg 305	
3 CSR 10-12.135	Conservation Commission		29 MoReg 1708	30 MoReg 195	
3 CSR 10-12.140	Conservation Commission		29 MoReg 1801	30 MoReg 306	
3 CSR 10-12.145	Conservation Commission		29 MoReg 1803	30 MoReg 306	
3 CSR 10-12.150	Conservation Commission		29 MoReg 1708	30 MoReg 196	
3 CSR 10-20.805	Conservation Commission		29 MoReg 1803	30 MoReg 306	
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4 CSR 30-5.060	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		30 MoReg 6		
4 CSR 30-12.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		29 MoReg 2212		
4 CSR 45-1.010	Athlete Agents	29 MoReg 1420	29 MoReg 1441	30 MoReg 196	
4 CSR 60-1.025	State Board of Barber Examiners		29 MoReg 1804		
4 CSR 65-1.020	Endowed Care Cemeteries		29 MoReg 1161R	30 MoReg 95W	
4 CSR 65-1.030	Endowed Care Cemeteries		29 MoReg 1161	30 MoReg 95W	
4 CSR 65-1.050	Endowed Care Cemeteries		29 MoReg 1162	30 MoReg 95W	
4 CSR 65-2.010	Endowed Care Cemeteries		29 MoReg 1162	30 MoReg 95W	
4 CSR 90-2.010	State Board of Cosmetology		29 MoReg 1292	30 MoReg 95	
4 CSR 90-2.020	State Board of Cosmetology		29 MoReg 1299	30 MoReg 98	
4 CSR 90-2.030	State Board of Cosmetology		29 MoReg 1299	30 MoReg 99	
4 CSR 90-4.010	State Board of Cosmetology		29 MoReg 1300	30 MoReg 99	
4 CSR 90-13.010	State Board of Cosmetology		29 MoReg 1303	30 MoReg 99	
4 CSR 95-1.005	Committee for Professional Counselors		30 MoReg 8		
4 CSR 95-1.010	Committee for Professional Counselors		30 MoReg 10R		
4 CSR 95-1.020	Committee for Professional Counselors		30 MoReg 10R 30 MoReg 10		
4 CSR 95-1.030	Committee for Professional Counselors		30 MoReg 10R		
4 CSR 95-1.040	Committee for Professional Counselors		30 MoReg 11R		
4 CSR 95-1.050	Committee for Professional Counselors		30 MoReg 11		
4 CSR 95-1.060	Committee for Professional Counselors		30 MoReg 15		
4 CSR 95-2.010	Committee for Professional Counselors		30 MoReg 18R 30 MoReg 18		
4 CSR 95-2.020	Committee for Professional Counselors		30 MoReg 19R 30 MoReg 20		
4 CSR 95-2.021	Committee for Professional Counselors		30 MoReg 25		
4 CSR 95-2.030	Committee for Professional Counselors		30 MoReg 27R 30 MoReg 27		
4 CSR 95-2.040	Committee for Professional Counselors		30 MoReg 29R		
4 CSR 95-2.050	Committee for Professional Counselors		30 MoReg 29R		
4 CSR 95-2.060	Committee for Professional Counselors		30 MoReg 29R		
4 CSR 95-2.065	Committee for Professional Counselors		30 MoReg 29		
4 CSR 95-2.070	Committee for Professional Counselors		30 MoReg 34R		
4 CSR 95-2.080	Committee for Professional Counselors		30 MoReg 34R		
4 CSR 95-3.010	Committee for Professional Counselors		30 MoReg 34R 30 MoReg 34		
4 CSR 95-3.015	Committee for Professional Counselors		30 MoReg 35		
4 CSR 95-3.020	Committee for Professional Counselors		30 MoReg 36R		
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4 CSR 95-3.050	Committee for Professional Counselors		30 MoReg 37R		
4 CSR 95-3.060	Committee for Professional Counselors		30 MoReg 37R		
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4 CSR 95-3.090	Committee for Professional Counselors		30 MoReg 38R		
4 CSR 95-3.100	Committee for Professional Counselors		30 MoReg 38R		
4 CSR 95-3.110	Committee for Professional Counselors		30 MoReg 39R		
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4 CSR 95-4.010	Committee for Professional Counselors		30 MoReg 42R		
4 CSR 100	Division of Credit Unions				29 MoReg 2225 29 MoReg 2331 30 MoReg 201
4 CSR 100-2.045	Division of Credit Unions		29 MoReg 2214		
4 CSR 100-2.205	Division of Credit Unions		29 MoReg 2215		
4 CSR 110-2.085	Missouri Dental Board		29 MoReg 1162	30 MoReg 99	
4 CSR 110-2.170	Missouri Dental Board		29 MoReg 1514	This Issue	
4 CSR 110-2.180	Missouri Dental Board		29 MoReg 1514R	This IssueR	
4 CSR 110-2.181	Missouri Dental Board		29 MoReg 1515R	This IssueR	
4 CSR 110-4.010	Missouri Dental Board		29 MoReg 1515	This Issue	
4 CSR 110-4.020	Missouri Dental Board		29 MoReg 1516	This Issue	
4 CSR 110-4.030	Missouri Dental Board		29 MoReg 1527	This Issue	
4 CSR 110-4.040	Missouri Dental Board		29 MoReg 1531	This Issue	
4 CSR 120-2.060	Missouri Dental Board		29 MoReg 1542		
4 CSR 150-2.080	State Board of Registration for the Healing Arts		29 MoReg 2216		
4 CSR 150-2.153	State Board of Registration for the Healing Arts		29 MoReg 781		
4 CSR 220-1.010	State Board of Pharmacy		30 MoReg 42		
4 CSR 220-2.010	State Board of Pharmacy		30 MoReg 42		
4 CSR 220-2.020	State Board of Pharmacy		30 MoReg 43		
4 CSR 220-2.030	State Board of Pharmacy		30 MoReg 46		
4 CSR 220-2.050	State Board of Pharmacy		30 MoReg 48		
4 CSR 220-5.030	State Board of Pharmacy		30 MoReg 48		
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4 CSR 230-1.020	State Board of Podiatric Medicine		29 MoReg 1444	30 MoReg 385	
4 CSR 230-1.030	State Board of Podiatric Medicine		29 MoReg 1444	30 MoReg 385	
4 CSR 230-2.010	State Board of Podiatric Medicine		29 MoReg 1445	30 MoReg 385	
4 CSR 230-2.020	State Board of Podiatric Medicine		29 MoReg 1446	30 MoReg 385	
4 CSR 230-2.021	State Board of Podiatric Medicine		29 MoReg 1447	30 MoReg 385	
4 CSR 230-2.022	State Board of Podiatric Medicine		29 MoReg 1447	30 MoReg 385	
4 CSR 230-2.030	State Board of Podiatric Medicine		29 MoReg 1448	30 MoReg 386	
4 CSR 230-2.041	State Board of Podiatric Medicine		29 MoReg 1450	30 MoReg 386	
4 CSR 230-2.050	State Board of Podiatric Medicine		29 MoReg 1451	30 MoReg 386	
4 CSR 230-2.065	State Board of Podiatric Medicine		29 MoReg 1452	30 MoReg 386	
4 CSR 230-2.070	State Board of Podiatric Medicine		29 MoReg 1453	30 MoReg 386	
4 CSR 240-3.513	Public Service Commission		30 MoReg 151		
4 CSR 240-29.010	Public Service Commission		30 MoReg 49		
4 CSR 240-29.020	Public Service Commission		30 MoReg 50		
4 CSR 240-29.030	Public Service Commission		30 MoReg 52		
4 CSR 240-29.040	Public Service Commission		30 MoReg 53		
4 CSR 240-29.050	Public Service Commission		30 MoReg 53		
4 CSR 240-29.060	Public Service Commission		30 MoReg 58		
4 CSR 240-29.070	Public Service Commission		30 MoReg 58		
4 CSR 240-29.080	Public Service Commission		30 MoReg 59		
4 CSR 240-29.090	Public Service Commission		30 MoReg 59		
4 CSR 240-29.100	Public Service Commission		30 MoReg 62		
4 CSR 240-29.110	Public Service Commission		30 MoReg 63		
4 CSR 240-29.120	Public Service Commission		30 MoReg 63		
4 CSR 240-29.130	Public Service Commission		30 MoReg 64		
4 CSR 240-29.140	Public Service Commission		30 MoReg 65		
4 CSR 240-29.150	Public Service Commission		30 MoReg 66		
4 CSR 240-29.160	Public Service Commission		30 MoReg 67		
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4 CSR 240-125.020	Public Service Commission		30 MoReg 366		
4 CSR 240-125.030	Public Service Commission		30 MoReg 366		
4 CSR 240-125.040	Public Service Commission		30 MoReg 367		
4 CSR 240-125.050	Public Service Commission		30 MoReg 370		
4 CSR 240-125.060	Public Service Commission		30 MoReg 370		
4 CSR 240-125.070	Public Service Commission		30 MoReg 373		

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4 CSR 245-5.020	Real Estate Appraisers		29 MoReg 1173	30 MoReg 100	
4 CSR 245-5.030	Real Estate Appraisers		29 MoReg 1175	30 MoReg 101R	
4 CSR 245-9.010	Real Estate Appraisers		29 MoReg 1175	30 MoReg 101	
4 CSR 250-5.030	Missouri Real Estate Commission		30 MoReg 268		
4 CSR 267-4.020	Office of Tattooing, Body Piercing and Branding		29 MoReg 1542		
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5 CSR 50-340.150	Division of School Improvement		29 MoReg 1806R 29 MoReg 1806		
5 CSR 60-100.050	Division of Career Education		29 MoReg 1709		
5 CSR 80-670.100	Teacher Quality and Urban Education		29 MoReg 1809		
5 CSR 80-800.200	Teacher Quality and Urban Education		29 MoReg 1711		
5 CSR 80-800.220	Teacher Quality and Urban Education		29 MoReg 1711		
5 CSR 80-800.230	Teacher Quality and Urban Education		29 MoReg 1714		
5 CSR 80-800.260	Teacher Quality and Urban Education		29 MoReg 1715		
5 CSR 80-800.270	Teacher Quality and Urban Education		29 MoReg 1716		
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5 CSR 90-7.300	Vocational Rehabilitation		29 MoReg 1052		
5 CSR 90-7.310	Vocational Rehabilitation		29 MoReg 1053		
5 CSR 90-7.320	Vocational Rehabilitation		29 MoReg 1053		
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7 CSR 10-25.010	Missouri Highways and Transportation Commission				30 MoReg 321 This Issue
7 CSR 10-25.040	Missouri Highways and Transportation Commission		29 MoReg 1352	30 MoReg 386	
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9 CSR 10-5.205	Director, Department of Mental Health		30 MoReg 270		
9 CSR 10-31.014	Director, Department of Mental Health	29 MoReg 1507	29 MoReg 1544	30 MoReg 306	
9 CSR 25-3.030	Fiscal Management		This Issue		
9 CSR 30-3.132	Certification Standards	29 MoReg 2255	29 MoReg 2258 This Issue		
9 CSR 45-2.015	Division of Mental Retardation and Developmental Disabilities	29 MoReg 1635	29 MoReg 1725		
9 CSR 45-2.017	Division of Mental Retardation and Developmental Disabilities		29 MoReg 2258		
9 CSR 45-5.020	Division of Mental Retardation and Developmental Disabilities		29 MoReg 1455R	30 MoReg 307R	
9 CSR 45-5.030	Division of Mental Retardation and Developmental Disabilities		29 MoReg 1455R	30 MoReg 308R	
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10 CSR 10-6.061	Air Conservation Commission		29 MoReg 1193	30 MoReg 102	
10 CSR 10-6.065	Air Conservation Commission		30 MoReg 153		30 MoReg 322
10 CSR 10-6.120	Air Conservation Commission		29 MoReg 1196	30 MoReg 308	
10 CSR 25-17.010	Hazardous Waste Management Commission		29 MoReg 794	30 MoReg 308W	30 MoReg 323
10 CSR 25-17.020	Hazardous Waste Management Commission		29 MoReg 795	30 MoReg 308W	30 MoReg 323
10 CSR 25-17.030	Hazardous Waste Management Commission		29 MoReg 796	30 MoReg 308W	30 MoReg 323
10 CSR 25-17.040	Hazardous Waste Management Commission		29 MoReg 797	30 MoReg 309W	30 MoReg 323
10 CSR 25-17.050	Hazardous Waste Management Commission		29 MoReg 803	30 MoReg 309W	30 MoReg 323
10 CSR 25-17.060	Hazardous Waste Management Commission		29 MoReg 810	30 MoReg 309W	30 MoReg 323
10 CSR 25-17.070	Hazardous Waste Management Commission		29 MoReg 810	30 MoReg 310W	30 MoReg 323
10 CSR 25-17.080	Hazardous Waste Management Commission		29 MoReg 817	30 MoReg 310W	30 MoReg 323
10 CSR 25-17.090	Hazardous Waste Management Commission		29 MoReg 824	30 MoReg 310W	30 MoReg 323
10 CSR 25-17.100	Hazardous Waste Management Commission		29 MoReg 830	30 MoReg 310W	30 MoReg 323
10 CSR 25-17.110	Hazardous Waste Management Commission		29 MoReg 830	30 MoReg 311W	30 MoReg 323
10 CSR 25-17.120	Hazardous Waste Management Commission		29 MoReg 831	30 MoReg 311W	30 MoReg 323
10 CSR 25-17.130	Hazardous Waste Management Commission		29 MoReg 832	30 MoReg 311W	30 MoReg 323
10 CSR 25-17.140	Hazardous Waste Management Commission		29 MoReg 832	30 MoReg 311W	30 MoReg 323
10 CSR 25-17.150	Hazardous Waste Management Commission		29 MoReg 833	30 MoReg 312W	30 MoReg 323
10 CSR 25-17.160	Hazardous Waste Management Commission		29 MoReg 839	30 MoReg 312W	30 MoReg 323
10 CSR 25-17.170	Hazardous Waste Management Commission		29 MoReg 839	30 MoReg 312W	30 MoReg 323
10 CSR 40-10.020	Land Reclamation Commission		29 MoReg 1303		
10 CSR 40-10.030	Land Reclamation Commission		29 MoReg 1304		
10 CSR 40-10.040	Land Reclamation Commission		29 MoReg 1305		
10 CSR 40-10.050	Land Reclamation Commission		29 MoReg 1306		

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10 CSR 40-10.070	Land Reclamation Commission		29 MoReg 1308		
10 CSR 40-10.080	Land Reclamation Commission		29 MoReg 1311		
10 CSR 40-10.100	Land Reclamation Commission		29 MoReg 1313		
10 CSR 80	Solid Waste Management				30 MoReg 324
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11 CSR 40-6.020	Division of Fire Safety		29 MoReg 1809	This Issue	
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11 CSR 40-6.031	Division of Fire Safety		29 MoReg 1812	This Issue	
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11 CSR 40-6.080	Division of Fire Safety		29 MoReg 1816	This Issue	
11 CSR 45-1.090	Missouri Gaming Commission		30 MoReg 376		
11 CSR 45-1.100	Missouri Gaming Commission		29 MoReg 1464	30 MoReg 315	
11 CSR 45-4.260	Missouri Gaming Commission		29 MoReg 1464	30 MoReg 316	
11 CSR 45-5.200	Missouri Gaming Commission		30 MoReg 376		
11 CSR 45-12.090	Missouri Gaming Commission		29 MoReg 1464	30 MoReg 316	
11 CSR 45-30.025	Missouri Gaming Commission		30 MoReg 67		
11 CSR 45-30.030	Missouri Gaming Commission		30 MoReg 68		
11 CSR 45-30.035	Missouri Gaming Commission		30 MoReg 68		
11 CSR 45-30.040	Missouri Gaming Commission		30 MoReg 68		
11 CSR 45-30.050	Missouri Gaming Commission		30 MoReg 69R		
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11 CSR 45-30.070	Missouri Gaming Commission		30 MoReg 69		
11 CSR 45-30.135	Missouri Gaming Commission		30 MoReg 70		
11 CSR 45-30.140	Missouri Gaming Commission		30 MoReg 70		
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11 CSR 45-30.160	Missouri Gaming Commission		30 MoReg 71R		
11 CSR 45-30.170	Missouri Gaming Commission		30 MoReg 71R		
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11 CSR 45-30.200	Missouri Gaming Commission		30 MoReg 73		
11 CSR 45-30.205	Missouri Gaming Commission		30 MoReg 73		
11 CSR 45-30.210	Missouri Gaming Commission		30 MoReg 73		
11 CSR 45-30.220	Missouri Gaming Commission		30 MoReg 74R		
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11 CSR 45-30.240	Missouri Gaming Commission		30 MoReg 74R		
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11 CSR 45-30.355	Missouri Gaming Commission		30 MoReg 77		
11 CSR 45-30.370	Missouri Gaming Commission		30 MoReg 78		
11 CSR 45-30.525	Missouri Gaming Commission		30 MoReg 78		
11 CSR 45-30.545	Missouri Gaming Commission		30 MoReg 79		
11 CSR 45-30.575	Missouri Gaming Commission		30 MoReg 79		
11 CSR 45-30.600	Missouri Gaming Commission		30 MoReg 80		
11 CSR 50-2.311	Missouri State Highway Patrol	29 MoReg 1426	29 MoReg 1465	30 MoReg 105	
11 CSR 50-2.320	Missouri State Highway Patrol	29 MoReg 1428	29 MoReg 1467	30 MoReg 106	
11 CSR 75-13.010	Peace Officer Standards and Training Program		29 MoReg 2218		
11 CSR 75-13.030	Peace Officer Standards and Training Program		29 MoReg 2218		
11 CSR 75-13.060	Peace Officer Standards and Training Program		29 MoReg 2218		
11 CSR 75-14.030	Peace Officer Standards and Training Program		30 MoReg 163		
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12 CSR 10-5.060	Director of Revenue		30 MoReg 164R		
12 CSR 10-5.070	Director of Revenue		30 MoReg 164R		
12 CSR 10-5.075	Director of Revenue		30 MoReg 164R		
12 CSR 10-5.545	Director of Revenue		30 MoReg 165R		
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12 CSR 10-11.140	Director of Revenue		30 MoReg 167R		
12 CSR 10-23.290	Director of Revenue		29 MoReg 2259		
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12 CSR 10-25.050	Director of Revenue		30 MoReg 167		
12 CSR 10-26.040	Director of Revenue		30 MoReg 168		
12 CSR 10-26.130	Director of Revenue		29 MoReg 1550R	30 MoReg 316R	
12 CSR 10-26.140	Director of Revenue		29 MoReg 1550R	30 MoReg 317R	
12 CSR 10-26.150	Director of Revenue		29 MoReg 1550R	30 MoReg 317R	
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12 CSR 10-103.210	Director of Revenue		29 MoReg 1551	30 MoReg 317	
12 CSR 10-104.040	Director of Revenue		30 MoReg 83		
12 CSR 10-107.100	Director of Revenue		29 MoReg 2219		
12 CSR 10-110.400	Director of Revenue		30 MoReg 86		
12 CSR 10-114.100	Director of Revenue		30 MoReg 90		
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12 CSR 10-400.250	Director of Revenue		30 MoReg 93		
12 CSR 30-3.010	State Tax Commission		29 MoReg 1816		
12 CSR 30-3.020	State Tax Commission		29 MoReg 1816		
12 CSR 30-3.050	State Tax Commission		29 MoReg 1817		
12 CSR 40-40.170	State Lottery		29 MoReg 1467	30 MoReg 387	
12 CSR 40-40.270	State Lottery		29 MoReg 1467	30 MoReg 387	
12 CSR 40-50.040	State Lottery		29 MoReg 1468	30 MoReg 387	
12 CSR 40-85.170	State Lottery		29 MoReg 1468	30 MoReg 388	
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13 CSR 35-30.010	Children's Division	30 MoReg 233	30 MoReg 271		
13 CSR 35-50.010	Children's Division	30 MoReg 234	30 MoReg 272		
13 CSR 35-80.010	Children's Division	29 MoReg 1636	29 MoReg 1729	30 MoReg 388	
13 CSR 35-80.020	Children's Division	29 MoReg 1637	29 MoReg 1729	30 MoReg 388	
13 CSR 40-19.020	Division of Family Services	29 MoReg 1637	29 MoReg 1729		
13 CSR 40-110.020	Division of Family Services		29 MoReg 1554	30 MoReg 317	
13 CSR 70-10.015	Division of Medical Services		29 MoReg 1356	30 MoReg 106	
13 CSR 70-10.080	Division of Medical Services		29 MoReg 1359	30 MoReg 106	
13 CSR 70-10.110	Division of Medical Services	30 MoReg 235	30 MoReg 272		
13 CSR 70-15.110	Division of Medical Services	29 MoReg 1508	29 MoReg 1731	30 MoReg 317	
13 CSR 70-20.200	Division of Medical Services		30 MoReg 171		
13 CSR 70-26.010	Division of Medical Services		30 MoReg 383		
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15 CSR 30-51.160	Secretary of State		29 MoReg 1362	30 MoReg 106	
15 CSR 30-54.195	Secretary of State		30 MoReg 173		
15 CSR 30-54.215	Secretary of State	29 MoReg 1428R 29 MoReg 1428	29 MoReg 1468R 29 MoReg 1468	30 MoReg 196R 30 MoReg 196	
15 CSR 40-3.120	State Auditor	29 MoReg 1639R	29 MoReg 2261		
15 CSR 40-3.130	State Auditor	29 MoReg 1639	29 MoReg 2262		
15 CSR 40-3.140	State Auditor	29 MoReg 1651	29 MoReg 2274		
15 CSR 40-3.150	State Auditor	29 MoReg 1661	29 MoReg 2284		
15 CSR 40-3.160	State Auditor	29 MoReg 1673	29 MoReg 2296		
15 CSR 60-14.010	Attorney General	29 MoReg 1508	29 MoReg 1557	This Issue	
15 CSR 60-14.020	Attorney General	29 MoReg 1509	29 MoReg 1557	This Issue	
15 CSR 60-14.030	Attorney General	29 MoReg 1509	29 MoReg 1557	This Issue	
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16 CSR 50-10.050	The County Employees' Retirement Fund		29 MoReg 1469	30 MoReg 318	
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 10-33.050	Office of the Director		This Issue		
19 CSR 20-3.080	Division of Environmental Health and Communicable Disease Prevention	29 MoReg 1510	29 MoReg 1560R 29 MoReg 1560	30 MoReg 196R 30 MoReg 197	
19 CSR 20-20.010	Division of Environmental Health and Communicable Disease Prevention		29 MoReg 1733	This Issue	
19 CSR 20-20.020	Division of Environmental Health and Communicable Disease Prevention		29 MoReg 1734	This Issue	
19 CSR 20-50.005	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 140	30 MoReg 173		
19 CSR 20-50.010	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 141	30 MoReg 174		
19 CSR 20-50.015	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 141	30 MoReg 174		
19 CSR 20-50.020	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 142	30 MoReg 176		
19 CSR 20-50.025	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 143	30 MoReg 178		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
19 CSR 20-50.030	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 144	30 MoReg 180		
19 CSR 20-50.035	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 145	30 MoReg 183		
19 CSR 20-50.040	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 145	30 MoReg 185		
19 CSR 25-36.010	Division of Administration		This Issue		
19 CSR 30-60.010	Division of Senior Services and Regulation		29 MoReg 1817R 29 MoReg 1818		
19 CSR 30-60.015	Division of Senior Services and Regulation		29 MoReg 1819		
19 CSR 30-60.020	Division of Health Standards and Licensure		29 MoReg 1819R		
19 CSR 30-60.025	Division of Senior Services and Regulation		29 MoReg 1820		
19 CSR 30-60.030	Division of Health Standards and Licensure		29 MoReg 1824R		
19 CSR 30-60.035	Division of Senior Services and Regulation		29 MoReg 1824		
19 CSR 30-60.040	Division of Health Standards and Licensure		29 MoReg 1828R		
19 CSR 30-60.045	Division of Senior Services and Regulation		29 MoReg 1828		
19 CSR 30-60.050	Division of Health Standards and Licensure		29 MoReg 1832R		
19 CSR 30-60.055	Division of Senior Services and Regulation		29 MoReg 1832		
19 CSR 30-60.060	Division of Health Standards and Licensure		29 MoReg 1836R		
19 CSR 30-60.061	Division of Senior Services and Regulation		29 MoReg 1836		
19 CSR 30-60.065	Division of Senior Services and Regulation		29 MoReg 1843		
19 CSR 30-60.070	Division of Health Standards and Licensure		29 MoReg 1848R		
19 CSR 30-60.071	Division of Senior Services and Regulation		29 MoReg 1848		
19 CSR 30-60.075	Division of Senior Services and Regulation		29 MoReg 1852		
19 CSR 30-60.080	Division of Senior Services and Regulation		29 MoReg 1855R 29 MoReg 1855		
19 CSR 30-60.090	Division of Senior Services and Regulation		29 MoReg 1864R 29 MoReg 1864		
19 CSR 30-60.095	Division of Senior Services and Regulation		29 MoReg 1874		
19 CSR 30-60.100	Division of Health Standards and Licensure		29 MoReg 1878R		
19 CSR 30-60.105	Division of Senior Services and Regulation		29 MoReg 1878		
19 CSR 30-60.110	Division of Health Standards and Licensure		29 MoReg 1882R		
19 CSR 30-60.115	Division of Senior Services and Regulation		29 MoReg 1882		
19 CSR 30-60.120	Division of Health Standards and Licensure		29 MoReg 1887R		
19 CSR 30-60.125	Division of Senior Services and Regulation		29 MoReg 1887		
19 CSR 30-60.135	Division of Senior Services and Regulation		29 MoReg 1891		
19 CSR 30-60.145	Division of Senior Services and Regulation		29 MoReg 1895		
19 CSR 30-60.155	Division of Senior Services and Regulation		29 MoReg 1898		
19 CSR 30-61.010	Division of Senior Services and Regulation		29 MoReg 1901R 29 MoReg 1901		
19 CSR 30-61.015	Division of Senior Services and Regulation		29 MoReg 1903R 29 MoReg 1903		
19 CSR 30-61.025	Division of Health Standards and Licensure		29 MoReg 1906R		
19 CSR 30-61.045	Division of Senior Services and Regulation		29 MoReg 1906R 29 MoReg 1906		
19 CSR 30-61.055	Division of Senior Services and Regulation		29 MoReg 1911R 29 MoReg 1911		
19 CSR 30-61.060	Division of Senior Services and Regulation		29 MoReg 1915		
19 CSR 30-61.065	Division of Senior Services and Regulation		29 MoReg 1919		
19 CSR 30-61.070	Division of Senior Services and Regulation		29 MoReg 1926		
19 CSR 30-61.075	Division of Senior Services and Regulation		29 MoReg 1932		
19 CSR 30-61.080	Division of Senior Services and Regulation		29 MoReg 1937		
19 CSR 30-61.085	Division of Health Standards and Licensure		29 MoReg 1940R		
19 CSR 30-61.086	Division of Senior Services and Regulation		29 MoReg 1940R 29 MoReg 1940		
19 CSR 30-61.090	Division of Senior Services and Regulation		29 MoReg 1948		
19 CSR 30-61.095	Division of Health Standards and Licensure		29 MoReg 1957R		
19 CSR 30-61.100	Division of Senior Services and Regulation		29 MoReg 1957		
19 CSR 30-61.105	Division of Health Standards and Licensure		29 MoReg 1964R		
19 CSR 30-61.110	Division of Senior Services and Regulation		29 MoReg 1964		
19 CSR 30-61.115	Division of Health Standards and Licensure		29 MoReg 1969R		
19 CSR 30-61.120	Division of Senior Services and Regulation		29 MoReg 1969		
19 CSR 30-61.125	Division of Health Standards and Licensure		29 MoReg 1975R		
19 CSR 30-61.130	Division of Senior Services and Regulation		29 MoReg 1975		
19 CSR 30-61.135	Division of Health Standards and Licensure		29 MoReg 1981R		
19 CSR 30-61.140	Division of Senior Services and Regulation		29 MoReg 1981		
19 CSR 30-61.145	Division of Health Standards and Licensure		29 MoReg 1986R		
19 CSR 30-61.150	Division of Senior Services and Regulation		29 MoReg 1986		
19 CSR 30-61.151	Division of Senior Services and Regulation		29 MoReg 1997		
19 CSR 30-61.155	Division of Senior Services and Regulation		29 MoReg 2001R 29 MoReg 2001		
19 CSR 30-61.165	Division of Senior Services and Regulation		29 MoReg 2005R 29 MoReg 2005		
19 CSR 30-61.170	Division of Senior Services and Regulation		29 MoReg 2009		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
19 CSR 30-61.175	Division of Health Standards and Licensure		29 MoReg 2013R		
19 CSR 30-61.180	Division of Senior Services and Regulation		29 MoReg 2013		
19 CSR 30-61.185	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.190	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.200	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.210	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.220	Division of Senior Services and Regulation		29 MoReg 2018R 29 MoReg 2018		
19 CSR 30-61.230	Division of Senior Services and Regulation		29 MoReg 2022		
19 CSR 30-62.010	Division of Senior Services and Regulation		29 MoReg 2024R 29 MoReg 2024		
19 CSR 30-62.022	Division of Senior Services and Regulation		29 MoReg 2026R 29 MoReg 2026		
19 CSR 30-62.032	Division of Health Standards and Licensure		29 MoReg 2029R		
19 CSR 30-62.042	Division of Senior Services and Regulation		29 MoReg 2029R 29 MoReg 2029		
19 CSR 30-62.052	Division of Senior Services and Regulation		29 MoReg 2034R 29 MoReg 2034		
19 CSR 30-62.060	Division of Senior Services and Regulation		29 MoReg 2038		
19 CSR 30-62.065	Division of Senior Services and Regulation		29 MoReg 2042		
19 CSR 30-62.070	Division of Senior Services and Regulation		29 MoReg 2049		
19 CSR 30-62.075	Division of Senior Services and Regulation		29 MoReg 2055		
19 CSR 30-62.080	Division of Senior Services and Regulation		29 MoReg 2060		
19 CSR 30-62.082	Division of Health Standards and Licensure		29 MoReg 2063R		
19 CSR 30-62.087	Division of Senior Services and Regulation		29 MoReg 2063R 29 MoReg 2063		
19 CSR 30-62.090	Division of Senior Services and Regulation		29 MoReg 2072		
19 CSR 30-62.092	Division of Health Standards and Licensure		29 MoReg 2082R		
19 CSR 30-62.100	Division of Senior Services and Regulation		29 MoReg 2082		
19 CSR 30-62.102	Division of Health Standards and Licensure		29 MoReg 2090R		
19 CSR 30-62.112	Division of Senior Services and Regulation		29 MoReg 2090R 29 MoReg 2090		
19 CSR 30-62.120	Division of Senior Services and Regulation		29 MoReg 2095		
19 CSR 30-62.122	Division of Health Standards and Licensure		29 MoReg 2100R		
19 CSR 30-62.125	Division of Senior Services and Regulation		29 MoReg 2100		
19 CSR 30-62.130	Division of Senior Services and Regulation		29 MoReg 2105		
19 CSR 30-62.132	Division of Health Standards and Licensure		29 MoReg 2111R		
19 CSR 30-62.140	Division of Senior Services and Regulation		29 MoReg 2111		
19 CSR 30-62.142	Division of Health Standards and Licensure		29 MoReg 2116R		
19 CSR 30-62.150	Division of Senior Services and Regulation		29 MoReg 2116		
19 CSR 30-62.151	Division of Senior Services and Regulation		29 MoReg 2121		
19 CSR 30-62.152	Division of Health Standards and Licensure		29 MoReg 2126R		
19 CSR 30-62.162	Division of Senior Services and Regulation		29 MoReg 2126R 29 MoReg 2126		
19 CSR 30-62.172	Division of Senior Services and Regulation		29 MoReg 2130R 29 MoReg 2130		
19 CSR 30-62.182	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.192	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.202	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.212	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.222	Division of Senior Services and Regulation		29 MoReg 2135R 29 MoReg 2135		
19 CSR 30-62.224	Division of Senior Services and Regulation		29 MoReg 2140		
19 CSR 30-62.226	Division of Senior Services and Regulation		29 MoReg 2146		
19 CSR 30-62.228	Division of Senior Services and Regulation		29 MoReg 2149		
19 CSR 30-62.230	Division of Senior Services and Regulation		29 MoReg 2152R 29 MoReg 2152		
19 CSR 30-62.240	Division of Senior Services and Regulation		29 MoReg 2156		
19 CSR 30-82.050	Division of Senior Services and Regulation		29 MoReg 2305		
19 CSR 30-82.090	Division of Health Standards and Licensure		28 MoReg 2254		
19 CSR 30-83.010	Division of Senior Services and Regulation		29 MoReg 1567	30 MoReg 318	
19 CSR 30-86.012	Division of Health Standards and Licensure		29 MoReg 2307		
19 CSR 30-86.022	Division of Health Standards and Licensure		29 MoReg 1362	30 MoReg 106	
19 CSR 30-86.032	Division of Health Standards and Licensure		29 MoReg 2308		
19 CSR 30-86.042	Division of Health Standards and Licensure		29 MoReg 2309		
19 CSR 30-89.010	Division of Health Standards and Licensure		29 MoReg 1568R	30 MoReg 318R	
19 CSR 30-90.010	Division of Senior Services and Regulation		29 MoReg 1569	30 MoReg 318	
19 CSR 30-90.020	Division of Senior Services and Regulation		29 MoReg 1570	30 MoReg 318	
19 CSR 30-90.030	Division of Health Standards and Licensure		29 MoReg 1574R	30 MoReg 319R	
19 CSR 30-90.040	Division of Senior Services and Regulation		29 MoReg 1574	30 MoReg 319	
19 CSR 30-90.050	Division of Senior Services and Regulation		29 MoReg 1579	30 MoReg 319	
19 CSR 30-90.060	Division of Senior Services and Regulation		29 MoReg 1581	30 MoReg 319	
19 CSR 30-90.070	Division of Senior Services and Regulation		29 MoReg 1582	30 MoReg 319	
19 CSR 30-90.080	Division of Health Standards and Licensure		29 MoReg 1587R	30 MoReg 319R	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
19 CSR 60-50	Missouri Health Facilities Review Committee				29 MoReg 2332 30 MoReg 201 30 MoReg 391
	DEPARTMENT OF INSURANCE				
20 CSR	Medical Malpractice				27 MoReg 415 28 MoReg 489 29 MoReg 505 This Issue
20 CSR	Sovereign Immunity Limits				27 MoReg 41 27 MoReg 2319 28 MoReg 2265 30 MoReg 108
20 CSR 10-1.020	General Administration		29 MoReg 1368	30 MoReg 106	
20 CSR 400-2.170	Life, Annuities and Health		29 MoReg 1755		
20 CSR 500-2.300	Property and Casualty		29 MoReg 2223		
20 CSR 700-6.100	Licensing	29 MoReg 2209	29 MoReg 1587	30 MoReg 388	
20 CSR 700-6.150	Licensing	29 MoReg 2209	29 MoReg 1590	30 MoReg 388	
20 CSR 700-6.160	Licensing		29 MoReg 1593	30 MoReg 389	
20 CSR 700-6.170	Licensing		29 MoReg 1597	30 MoReg 389	
20 CSR 700-6.200	Licensing		29 MoReg 1597	30 MoReg 389	
20 CSR 700-6.250	Licensing		29 MoReg 1598	30 MoReg 389	
20 CSR 700-6.300	Licensing		29 MoReg 1598	30 MoReg 389	
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-2.010	Health Care Plan	30 MoReg 237R 30 MoReg 237	30 MoReg 275R 30 MoReg 275		
22 CSR 10-2.020	Health Care Plan	30 MoReg 240R 30 MoReg 240	30 MoReg 280R 30 MoReg 280		
22 CSR 10-2.030	Health Care Plan	30 MoReg 243R 30 MoReg 243	30 MoReg 283R 30 MoReg 283		
22 CSR 10-2.045	Health Care Plan	30 MoReg 244R 30 MoReg 244	30 MoReg 283R 30 MoReg 284		
22 CSR 10-2.055	Health Care Plan	30 MoReg 245R 30 MoReg 245	30 MoReg 284R 30 MoReg 284		
22 CSR 10-2.070	Health Care Plan	30 MoReg 246R 30 MoReg 246	30 MoReg 285R 30 MoReg 285		
22 CSR 10-2.075	Health Care Plan	30 MoReg 248R 30 MoReg 248	30 MoReg 286R 30 MoReg 287		
22 CSR 10-2.080	Health Care Plan	30 MoReg 249R 30 MoReg 250	30 MoReg 288R 30 MoReg 288		
22 CSR 10-3.010	Health Care Plan	30 MoReg 250	30 MoReg 289		
22 CSR 10-3.020	Health Care Plan	30 MoReg 253	30 MoReg 291		
22 CSR 10-3.030	Health Care Plan	30 MoReg 256	30 MoReg 294		
22 CSR 10-3.070	Health Care Plan	30 MoReg 257	30 MoReg 297		
22 CSR 10-3.075	Health Care Plan	30 MoReg 258	30 MoReg 298		
22 CSR 10-3.080	Health Care Plan	30 MoReg 259	30 MoReg 299		

Emergency Rules in Effect as of March 1, 2005

		Publication	Expires
Department of Agriculture			
Animal Health			
2 CSR 30-2.010	Health Requirements Governing the Admission of Livestock, Poultry and Exotic Animals Entering Missouri	29 MoReg 1417	March 1, 2005
2 CSR 30-2.010	Health Requirements Governing the Admission of Livestock, Poultry and Exotic Animals Entering Missouri	30 MoReg 139	May 31, 2005
2 CSR 30-6.020	Duties and Facilities of the Market/Sale Veterinarian	29 MoReg 1418	March 1, 2005
Department of Economic Development			
Athlete Agents			
4 CSR 45-1.010	Fees	29 MoReg 1420	March 7, 2005
Department of Mental Health			
Director, Department of Mental Health			
9 CSR 10-31.014	Waiver of Standard Means Test for Children in Need of Mental Health Services	29 MoReg 1507	March 13, 2005
Certification Standards			
9 CSR 30-3.132	Opioid Treatment Program	29 MoReg 2255	May 16, 2005
Division of Mental Retardation and Developmental Disabilities			
9 CSR 45-2.015	Criteria for MRDD Comprehensive Waiver Slot Assignment	29 MoReg 1635	April 15, 2005
Department of Public Safety			
Division of Fire Safety			
11 CSR 40-3.010	Fireworks—Licenses, Sales and Penalties	29 MoReg 1420	March 7, 2005
11 CSR 40-3.010	Fireworks—Licensing, Permits, Sales, Inspection, and Penalties	29 MoReg 1420	March 7, 2005
Missouri State Highway Patrol			
11 CSR 50-2.311	Bumpers	29 MoReg 1426	March 9, 2005
11 CSR 50-2.320	School Bus Inspection	29 MoReg 1428	March 9, 2005
Department of Revenue			
Director of Revenue			
12 CSR 10-41.010	Annual Adjusted Rate of Interest	30 MoReg 5	June 29, 2005
12 CSR 10-400.200	Special Needs Adoption Tax Credit	30 MoReg 357	July 15, 2005
Department of Social Services			
Children's Division			
13 CSR 35-30.010	Voluntary Placement Agreement Solely for the Purpose of Accessing Mental Health Services and Treatment for Children Under Age Eighteen (18)	30 MoReg 233	June 30, 2005
13 CSR 35-50.010	Accreditation as Evidence for Meeting Licensing Requirements	30 MoReg 234	June 30, 2005
13 CSR 35-80.010	Residential Foster Care Maintenance Methodology	29 MoReg 1636	March 30, 2005
13 CSR 35-80.020	Residential Care Agency Cost Reporting System	29 MoReg 1637	March 30, 2005
Family Support Division			
13 CSR 40-19.020	Low Income Home Energy Assistance Program	29 MoReg 1637	April 1, 2005
Division of Medical Services			
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance	30 MoReg 235	June 29, 2005
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	29 MoReg 1508	March 18, 2005
Elected Officials			
Secretary of State			
15 CSR 30-54.215	Accredited Investor Exemption	29 MoReg 1428	March 9, 2005
15 CSR 30-54.215	Accredited Investor Exemption	29 MoReg 1428	March 9, 2005
State Auditor			
15 CSR 40-3.120	Calculation and Revision of Property Tax Rates	29 MoReg 1639	April 1, 2005
15 CSR 40-3.130	Calculation and Revision of Property Tax Rates by School Districts Calculating a Separate Tax Rate for Each Sub-Class of Property	29 MoReg 1639	April 1, 2005
15 CSR 40-3.140	Calculation and Revision of Property Tax Rates by School Districts that Calculate a Single Property Tax Rate Applied to All Property	29 MoReg 1651	April 1, 2005

15 CSR 40-3.150	Calculation and Revision of Property Tax Rates by Political Subdivisions Other Than School Districts Calculating a Separate Property Tax Rate for Each Sub-Class of Property	29 MoReg 1661	April 1, 2005
15 CSR 40-3.160	Calculation and Revision of Property Tax Rates by Political Subdivision Other Than School Districts that Calculate a Single Property Tax Rate Applied to All Property	29 MoReg 1673	April 1, 2005
Attorney General			
15 CSR 60-14.010	Definitions	29 MoReg 1508	March 10, 2005
15 CSR 60-14.020	Contract Procedures	29 MoReg 1509	March 10, 2005
15 CSR 60-14.030	Documentation of Legal Practice	29 MoReg 1509	March 10, 2005

Department of Health and Senior Services

Division of Environmental Health and Communicable Disease Prevention

19 CSR 20-3.080	Description of Persons Qualified to Perform Percolation Tests, Soils Morphology Examinations in Determining Soil Properties for On-Site Sewage Disposal Systems and Installation of On-Site Wastewater Treatment Systems	29 MoReg 1510	March 10, 2005
19 CSR 20-50.005	Definitions	30 MoReg 140	June 29, 2005
19 CSR 20-50.010	Eligibility Requirements for Pharmacies, Hospitals and Nonprofit Clinics to Receive Donated Prescription Drugs	30 MoReg 141	June 29, 2005
19 CSR 20-50.015	Eligibility Requirements for Recipients in the Program	30 MoReg 141	June 29, 2005
19 CSR 20-50.020	Standards and Procedures for Donating Prescription Drugs	30 MoReg 142	June 29, 2005
19 CSR 20-50.025	Standards and Procedures for Accepting Donated Prescription Drugs	30 MoReg 143	June 29, 2005
19 CSR 20-50.030	Standards and Procedures for Inspecting and Storing Donated Prescription Drugs	30 MoReg 144	June 29, 2005
19 CSR 20-50.035	Standards and Procedures for Dispensing Donated Prescription Drugs	30 MoReg 145	June 29, 2005
19 CSR 20-50.040	Record Keeping Requirements	30 MoReg 145	June 29, 2005

Department of Insurance

Licensing

20 CSR 700-6.100	Fees and Renewals—Bail Bond Agents, General Bail Bond Agents and Surety Recovery Agents	29 MoReg 2209	June 29, 2005
20 CSR 700-6.150	Initial Basic Training for Bail Bond Agents, General Bail Bond Agents and Surety Recovery Agents	29 MoReg 2209	June 29, 2005

Missouri Consolidated Health Care Plan

Health Care Plan

22 CSR 10-2.010	Definitions	30 MoReg 237	June 29, 2005
22 CSR 10-2.010	Definitions	30 MoReg 237	June 29, 2005
22 CSR 10-2.020	Membership Agreement and Participation Agreement	30 MoReg 240	June 29, 2005
22 CSR 10-2.020	Subscriber Agreement and General Membership Provisions	30 MoReg 240	June 29, 2005
22 CSR 10-2.030	Contributions	30 MoReg 243	June 29, 2005
22 CSR 10-2.030	Contributions	30 MoReg 243	June 29, 2005
22 CSR 10-2.045	Co-Pay and PPO Plan Summaries	30 MoReg 244	June 29, 2005
22 CSR 10-2.045	Plan Utilization Review Policy	30 MoReg 244	June 29, 2005
22 CSR 10-2.055	Co-Pay and PPO Plan Benefit Provisions and Covered Charges	30 MoReg 245	June 29, 2005
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	30 MoReg 245	June 29, 2005
22 CSR 10-2.070	Coordination of Benefits	30 MoReg 246	June 29, 2005
22 CSR 10-2.070	Coordination of Benefits	30 MoReg 246	June 29, 2005
22 CSR 10-2.075	Review and Appeals Procedure	30 MoReg 248	June 29, 2005
22 CSR 10-2.075	Review and Appeals Procedure	30 MoReg 248	June 29, 2005
22 CSR 10-2.080	Miscellaneous Provisions	30 MoReg 249	June 29, 2005
22 CSR 10-2.080	Miscellaneous Provisions	30 MoReg 250	June 29, 2005
22 CSR 10-3.010	Definitions	30 MoReg 250	June 29, 2005
22 CSR 10-3.020	Subscriber Agreement and General Membership Provisions	30 MoReg 253	June 29, 2005
22 CSR 10-3.030	Public Entity Membership Agreement and Participation Period	30 MoReg 256	June 29, 2005
22 CSR 10-3.070	Coordination of Benefits	30 MoReg 257	June 29, 2005
22 CSR 10-3.075	Review and Appeals Procedure	30 MoReg 258	June 29, 2005
22 CSR 10-3.080	Miscellaneous Provisions	30 MoReg 259	June 29, 2005

Executive Orders	Subject Matter	Filed Date	Publication
	2005		
05-01	Rescinds Executive Order 01-09	January 11, 2005	30 MoReg 261
05-02	Restricts new lease and purchase of vehicles, cellular phones, and office space by executive agencies	January 11, 2005	30 MoReg 262
05-03	Closes state's Washington D.C. office	January 11, 2005	30 MoReg 264
05-04	Authorizes Transportation Director to issue declaration of regional or local emergency with reference to motor carriers	January 11, 2005	30 MoReg 266
05-05	Establishes the 2005 Missouri State Government Review Commission	January 24, 2005	30 MoReg 359
05-06	Bans the use of video games by inmates in all state correctional facilities	January 24, 2005	30 MoReg 362
05-07	Consolidates the Office of Information Technology to the Office of Administration's Division of Information Services	January 26, 2005	30 MoReg 363
05-08	Consolidates the Division of Design and Construction to Division of Facilities Management, Design and Construction	February 2, 2005	This Issue
05-09	Transfers the Missouri Head Injury Advisory Council to the Department of Health and Senior Services	February 2, 2005	This Issue
05-10	Transfers and consolidates in-home care for elderly and disabled individuals from the Department of Elementary and Secondary Education and the Department of Social Services to the Department of Health and Senior Services	February 3, 2005	This Issue
05-11	Rescinds Executive Order 04-22 and orders the Department of Health and Senior Services and all Missouri health care providers and others that possess influenza vaccine adopt the Center for Disease Control and Prevention, Advisory Committee for Immunization Practices expanded priority group designations as soon as possible and update the designations as necessary	February 3, 2005	This Issue
	2004		
04-01	Establishes the Public Safety Officer Medal of Valor, and the Medal of Valor Review Board	February 3, 2004	29 MoReg 294
04-02	Designates staff having supervisory authority over agencies	February 3, 2004	29 MoReg 297
04-03	Creates the Missouri Automotive Partnership	January 14, 2004	29 MoReg 151
04-04	Creates the Missouri Methamphetamine Education and Prevention Task Force	January 27, 2004	29 MoReg 154
04-05	Establishes a Missouri Methamphetamine Treatment Task Force	January 27, 2004	29 MoReg 156
04-06	Establishes a Missouri Methamphetamine Enforcement and Environmental Protection Task Force	January 27, 2004	29 MoReg 158
04-07	Establishes the Missouri Commission on Patient Safety and supercedes Executive Order 03-16	February 3, 2004	29 MoReg 299
04-08	Transfers the Governor's Council on Disability and the Missouri Assistive Technology Advisory Council to the Office of Administration	February 3, 2004	29 MoReg 301
04-09	Requires vendors to disclose services performed offshore. Restricts agencies in awarding contracts to vendors of offshore services	March 17, 2004	29 MoReg 533
04-10	Grants authority to Director of Department of Natural Resources to temporarily waive regulations during periods of emergency and recovery	May 28, 2004	29 MoReg 965
04-11	Declares regional state of emergency because of the need to repair electrical outages by various contractors, including a Missouri contractor. Allows temporary exemption from federal regulations	May 28, 2004	29 MoReg 967
04-12	Declares emergency conditions due to severe weather in all Northern and Central Missouri counties	June 4, 2004	29 MoReg 968
04-13	Declares June 11, 2004 to be day of mourning for President Ronald Reagan	June 7, 2004	29 MoReg 969
04-14	Establishes an Emancipation Day Commission. Requests regular observance of Emancipation Proclamation on June 19	June 17, 2004	29 MoReg 1045
04-15	Declares state of emergency due to lost electrical service in St. Louis region	July 7, 2004	29 MoReg 1159
04-16	Orders a special census be taken in the City of Licking	July 23, 2004	29 MoReg 1245
04-17	Declares that Missouri implement the Emergency Mutual Aid Compact (EMAC) agreement with the State of Florida	August 18, 2004	29 MoReg 1347
04-18	Accepts retrocession of federal jurisdiction over the St. Louis Army Ammunition Plant	August 25, 2004	29 MoReg 1349
04-19	Implements the EMAC with the State of Florida, activates the EMAC plan, and authorizes the use of the Missouri National Guard	September 10, 2004	29 MoReg 1430

Executive Orders	Subject Matter	Filed Date	Publication
04-20	Reestablishes the Poultry Industry Committee	September 14, 2004	29 MoReg 1432
04-21	Directs the creation of the Forest Utilization Committee within the Missouri Department of Conservation	September 14, 2004	29 MoReg 1434
04-22	Requests health care providers limit influenza vaccinations to high risk persons. Orders various actions by providers, Missouri Department of Health and Senior Services, and Attorney General's Office regarding influenza vaccine supply.	October 25, 2004	29 MoReg 1683
04-23	Creates the Forest Utilization Committee within the Missouri Department of Conservation. Supersedes and rescinds Executive Order 04-21	October 22, 2004	29 MoReg 1685
04-24	Rescinds Executive Order 03-15	October 22, 2004	29 MoReg 1687
04-25	Rescinds Executive Order 03-27	October 22, 2004	29 MoReg 1688
04-26	Authorizes Adjutant General to recognize Noncommissioned Officers with a First Sergeant's ribbon	November 1, 2004	29 MoReg 1791
04-27	Closes state offices Friday November 26, 2004	November 1, 2004	29 MoReg 1792
04-28	Closes state offices Monday, January 10, 2005	December 6, 2004	29 MoReg 2256
04-29	Rescinds Executive Order 04-22	January 4, 2005	30 MoReg 147

The rule number and the MoReg publication date follow each entry to this index.

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